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ABSTRACT

Intended for parents of emotionally disturbed children, the booklet presents background information on the nature and treatment of emotional disorders. Two accounts by parents are provided. Among topics covered in section 1 are identification, characteristics, types of programs (residential and nonresidential), types of professionals, different kinds of therapies (psychotherapy, behavior therapy), school services, parent role, and a model program for elementary students with emotional/behavior disorders. Section 2 details publicly supported services and programs in Minnesota, including hospital-based programs, community mental health centers, county services, and residential treatment centers. (CL)

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a guidebook

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for parents of children with emotional disorders

PACER Center, Inc.

a guidebook for parents of children with emotional disorders

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PREFACE

TWO STORIES BY PARENTS

This is a book for parents. Accordingly, it seemed appropriate to begin with two stories, both written by the parents of children with serious emotional disorders. Their accounts tell about the searches they made - for services, for emotional strength and acceptance, for understanding from others, and for comprehension of what's happening. Perhaps a glimpse into what they've gone through and the answers they've found will help those of you who are beginning the search to feel less alone.

For most of us, the intensity of a painful experience seems to fade gradually with the passage of time. It is part of a healing process that allows us to continue with our lives. But for Matt, the intensity of his pain has remained with him...a kind of "hidden heartache" that interferes with his ability to cope and react to life in a normal way. Just to look at Matt, he appears to be like any other six year old. He likes Star Wars, Pac Man, riding his Big Wheel, and playing baseball... and sometimes he likes to play with other children.

The difference is that although Matt may look like other children, he is not. Matt, who came to us from Korea at six months, was suffering from a serious emotional disorder. When the flight aide placed Matt in my arms, there was an unmistakable difference in the way he reacted. He didn't cry or move but maintained a rigid position and continued a cold, blank stare. I was reassured that sometimes children react this way from a long flight. However, the staring continued, compounded with head banging, poor appetite, and stomach problems.

As time progressed, Matt spent much of his time rocking, banging his head, and exhibiting destructive, overly active and inappropriate behavior. When he was eighteen months, I felt I would no longer accept the many excuses for his behavior from family members, doctors, and other professionals. I was determined that my son would receive the help he so desperately needed.

I thought, "After all, I am Matt's mother. I live with this child all the time, and I know he is not improving. In fact, he is distancing himself further away."

And so my search began for help for Matt. Unfortunately, I did not realize at the time that the number of programs, available treatment, or even recognition of emotional disorders in young children is very limited. At the beginning, the treatment centered around

sessions with a child psychologist who took an in-depth history of Matt, his behaviors at home and those observed during our visits with the doctor. There was a great deal of discussion concerning parenting skills, and the doctor provided suggestions for working with Matt at home.

Most distressing during this first phase of treatment was the endless number of questions asked me in the sessions. It seemed as if they were probing for some "deep, dark secret" that would reveal why Matt was responding the way he did to the world around him.

But there was no hidden resentment toward Matt. He had come to us with the damage having already been done within the critical first six months of life. It has taken me a long time to recover from the misplaced guilt that was imposed on me in the beginning.

After six months of treatment, it was determined that more intensive observation of Matt was needed in a hospital setting. I felt so miserable and guilty at the thought of Matt going into the hospital. However, I was exhausted trying to cope with his behaviors all day long. He had to be watched constantly. There was really no other choice. Even routine kinds of activities that most people take for granted such as grocery shopping, visiting friends, and attending church were all but impossible when Matt was along.

Also, it was very difficult to find anyone who was willing to watch him so that I could get out myself. Many times I had to drive fifteen miles to my parents' home to have Matt watched - or they would have to drive to my house - so that I could get some of those errands accomplished.

I envied those parents who didn't have all these problems and indeed felt angry, too, that no one other than my family offered help. Friends and acquaintances would invite my daughter to come to their home, but no one wanted to deal with the "strange little boy."

Matt was hospitalized for one month. In that time we were carefully scrutinized concerning our methods of parenting, our own childhood experience and families. For much of the hospital stay, we were not allowed to visit with Matt unless a staff member was in attendance. Some of the staff were kind and helpful. Others were uncaring and judgmental.

I longed to tell them how I would love to come and judge and comment upon every interaction they had with their own children. I highly doubt they would pass the stringent criteria they had set for us.

During that month I tried to focus my thoughts on one goal: that the doctor could find what Matt's problems were and begin some course of treatment. At the end of the month, the doctor had indeed observed many of the behaviors that I had described to her so many times during our sessions at her office. She recommended Matt for a new hospital-based program that worked with emotionally disturbed children.

However, it would have to be determined if Matt fit the criteria of the new program. Fortunately, after an interview with program staff, it was found that Matt was appropriate for their program.

He did make progress during the next two years in this program. He was in a small, safe environment with teacher/therapists to work with him. There was also a therapist who helped parents understand their child's behaviors. Learning effective and new ways to parent Matt and gaining a greater understanding of his delayed development was most helpful.

Again, during this time, I was put through intensive analysis. When handled correctly, analysis/counseling can provide a period of true growth and understanding. However, when the counseling is provided in an inconsistent manner, the effects can be very damaging to one's self esteem.

One week the therapist or teachers would praise and encourage me in how I was working with Matt...by the next week I was either blamed or criticized for some of the same actions. It was difficult to cope with these methods.

After leaving the hospital program, Matt was referred for treatment with a child psychologist who has established an excellent relationship with him. We see another doctor in the same group for counseling. The attitudes that these doctors have toward parents is very different from what I had experienced before. They have been very open, honest and consistent in their dealings with us. Their major focus has not been to put needless guilt on a family who has already been pushed to an almost unbearable level of stress. Rather, they focus on ways to cope with, understand, and accept Matt's disorder. His problem is internalized. As a family, we can act in ways that will stimulate growth in Matt and help him feel a sense of safety. Nevertheless, to be realistic is to accept that he may never be able to function like other children.

Matt is now in a public school and receiving services from special ed through an emotional/behavior disorder program. Within the public school system, I have found there are those persons who care deeply about doing what is appropriate for Matt. Those are the teachers who care deeply about doing what is appropriate for him. These are the teachers and administrators who have taken the time to look carefully at his long history of emotional problems, listened to my observations of Matt and his feelings about school, and implemented suggestions from his doctor. These people feel it is important to work as a team.

Unfortunately, there have been an equal number of school personnel who cannot see past Matt's normal physical appearance and make snap judgements and recommendations that I feel are detrimental to his well being. These teachers will not accept that a bright child who looks so normal - and at times, who can function normally - can have serious emotional problems.

It is their opinion that he is manipulative and spoiled. How I wish he were! I could do something about that.

Matt is so consumed with fears that he feels he may be killed. He believes that teachers and other children can change into monsters. He has a distorted perception of what is actually happening, and I worry that he will injure another child or himself while at school.

Being the parent of an emotionally disturbed child has certainly not been easy. At times, I feel so tired and sad and helpless. Now, six years later, I wonder where I found the strength to make it through those early years. Many times I felt as if I was struggling all alone, and I wondered if there was any hope for Matt. It seemed when things were at their lowest point, something happened that renewed my faith in Matt or in those people I had felt were abandoning us.

To parents who wonder how they are going to survive living with an E.D. child, I want to say that there are people who do care about your child and you. Sometimes, you have to be the one to seek out these people.

PACER Center was there for me three and a half years ago at a time when I was questionning whether anyone really cared what happened to Matt. At that time, I was unaware that my child would be entitled to a free, appropriate public education under PL94-142. I received information from PACER staff and attended workshops on the basic rights and laws and received advocacy and assertiveness training. Since most of PACER's staff are themselves parents of handicapped children, they have a deep concern and empathy for all parents of handicapped children. I learned that parents can be an important part in developing appropriate programs for their child, and I gained the skills and confidence to become a good advocate for my son. PACER's services are free to parents. Don't hesitate to call them or to attend one of their workshops. Emotionally disturbed children do have the right to an appropriate education. PACER staff are caring, knowledgeable, and supportive and want to help you understand these rights.

In the future I would like to see the establishment of support groups for parents of ED children. Parents need to feel less alone. Professionals need to consider parents as individuals. We do not all fit into one mold. It does not help to blame parents for their child's problem. It does help to enable them to understand, to cope with, and to accept the child and to teach them ways to help their youngster.

Professionals work with our children on a limited basis. The youngsters do present frustrations. However, professionals are able to have a break from this frustration. Parents have to cope with the situation on a daily basis.

Parents need to show appreciation to those professionals who put forth an extra effort with their child. Professionals need to feel that we recognize and value these efforts.

Parents and professionals need to work as a team.

In the past six years, my life has changed dramatically. My values and priorities are different. I've become a much stronger person because I've had to be stronger. Having Matt has put an enormous amount of stress on our family. Not all family members are able to accept or cope with an emotionally disturbed child. Some people may never be able to overcome their feelings of anger, frustration, and resentment.

That is a part of reality that I have come to accept.

Matt's future is uncertain at this time. He makes progress and also experiences regression. During these years, I have had to give a lot of myself; it has been worth it. But I have also learned it is important to do something for myself, too.

Written by Matt's mother

Most of us are familiar with the military term, "no man's land (NML)", which is defined as an "indefinite area of operation, involvement and jurisdiction between two conflicting sides."

I am a psychologist who has spent most of his 14-year career working with children and families. I am also the parent of a 10 year old child with a diagnosis of "pervasive developmental delay." A role conflict like that meant a lot of early hiding in an emotional NML (any resemblance between the abbreviation for "no man's land" and "normal" is purely coincidental!)

A few examples of my thinking over the years will illustrate what spending time in NML is all about: "If she were a client who did that instead of my own child, would I have reacted in the same irrational way?" (operation); "I have to deal with that stuff all day at work, Dear. I don't want to deal with it when I come home," (involvement); "I help all of those other kids, and I can't 'fix up' my own child" (jurisdiction).

During those early years, being in NML was manifested by periods of physical and emotional inaccessibility on my part (lots of sports and work), denial ("She'll probably outgrow it"), and projection of blame and displacement of anger towards my wife ("If you would only be more relaxed when you're around her"..."You were the one who wanted a second child; I was content to stop after one.")

The denial aspect was the hardest to pull off because by the time our daughter was six to twelve months old, she was showing some very atypical behavior, some of which was autistic-like. I remember,

at the time, flashing back to early graduate school days when I had seen many children diagnosed as autistic. I recall sharing commonly held fears with my fellow students about how would or could we deal with the daily traumas of parenting a child like "that." Keep in mind, too, that in those days, "poor" parenting was considered in many circles to be a major contributing factor to the development of autism and related disorders.

By the time our daughter reached late preschool/early school age, I was becoming known as "someone who did good work with kids." However, our daughter was also becoming well known, though for different reasons.

A situation which I have titled, "You Could Hear a Pin Drop in the Grocery Store Incident" will serve as a good illustration. At the time, our daughter was in the habit of screaming for no externally apparent reason. One day, she and I were grocery shopping when she let out with a shriek. After that, the only sound you could hear was the Musak. Unfortunately, this was one of the first times when both the parent and the psychologist had to face the Musak together. In addition to the stares of other shoppers, who should be coming around the corner but the mother of a family I was working with! She asked, "What's the matter?", and I replied with considerable humility, "I don't know; she frequently does that."

The battle in me had been joined. The opposing sides (parent/psychologist) had converged. There was no more NML to go to. It was no longer possible, at any level, to deny the problem. Emotional inaccessibility was a sure ticket to the divorce court and/or the therapist's office. I would have needed a lobotomy in order to continue projecting guilt or displacing anger towards my wife.

During those years, it was finally necessary to come to terms with a host of "parent" issues, including:

(a) questions about where I might have failed my daughter during her infancy and toddler years,

(b) angry feelings towards her, including a wish she had never been born,

(c) scapegoating (blaming her for family disharmony),

(d) paranoia (real and not so real - wondering why the neighbors avoided us),

(e) unfair comparisons with siblings and other children,

(f) feeling judged by "society,"

(g) searching for the holy grail (magic cure), ad infinitum, ad nauseaum.

As a psychologist, there were a number of related, but nonetheless unique issues which also needed to be addressed. Some of those included:

(a) internal role (parent vs. psychologist) conflict, especially

at school staffings both for my own child and for my clients,

(b) questions about how my own child's problems might affect my practice as far as referrals were concerned,

(c) wondering what my professional peers thought of me,

(d) doubts about how much credibility I or anyone else should give to any 'professional opinions' I might have about our daughter,

(e) sadness after being of help to some other family and, yet, unable to 'cure' my own daughter, etc.

Therefore, while there may be some advantages to being a psychologist/parent of a handicapped child (for example, having professional 'connections' and a more sophisticated knowledge base), it is really a toss up as to whether those factors totally counterbalance the disadvantages. Furthermore, there are situations where knowing too much (for instance, about a long term prognosis or the 'politics' of a parent-teacher staffing) can - at best - leave you feeling powerless and - at worst - leave you in a state of paralyzing rage.

In conclusion, I would like to offer a brief and admittedly incomplete list of suggestions, which many readers will already find familiar.

(1) We all know there are certain undeniable truths, such as the sky is blue, the grass is green, we all die, and we all pay taxes. I would like to add a couple more. First, there is no holy grail. However, keep searching. It will sharpen your survival skills. Second, there is no 'free lunch', PL94-142 notwithstanding.

(2) It is easy to fall into a vicious repetitive cycle, where in relation to your child, you vacillate between three roles which are: (a) Victim ("This kid makes me feel so burned out"); (b) Persecutor, where the feelings of hurt associated with being a victim are transformed into irrational angry overreactions toward your child; and (c) Enabler, where the overwhelming guilt derived from your overreaction leads to overprotection of your child from outside forces (school, relatives, neighbors) or to granting your child's undeserved or unwarranted requests or demands. This, in turn, serves to foster or reinforce the occurrence of further abnormal regressive behavior which will eventually lead back into the hurt-angle-guilt cycle.

(3) Use humor to lighten the anguish. My wife's early diary of our child's behavior would have Irma Bombeck in stitches. For example, one of our daughter's favorite idiosyncratic expletives was "Flat rabbit", which, when younger, she would yell when frustrated. One day in a restaurant, my wife told her to order the rabbit so she could "eat a flat rabbit". Everyone, including our daughter, thought it was hilarious. Other than occasional

joking about the restaurant situation, we never heard her use that expression again.

(4) Figure out what your child's capabilities are and multiply by two. Inadvertently, it may have become easy to underestimate your child's strengths. To counter the underestimation means taking a lot of risks, including risks of public embarrassment or disapproval, as well as self esteem risks to your child. Take them anyway, and trust your judgement. There is a very fine line between high versus unrealistic expectations. If you are going to err, do so on the side of unreality. Your child won't go crazy, and chances are you won't either.

(5) Within your family, stay constantly aware of each other's needs and don't hesitate about being honest with regard to how much support you need and how much support you have left to give. However, chronic chest beating is not allowed. Having very supportive friends and/or family, especially if they have children, is also crucial for the maintenance of your sanity.

(6) When you see or hear your child doing something, don't automatically assume that it's abnormal, bizarre, or strange. Living with a handicapped child means you're constantly being exposed to unusual situations and, therefore, always assuming the worst. Don't feel bad though. Mental health and special education professionals have the same problem. Like yourself, they are also overexposed to abnormal situations and may tend to link any behavior to a handicap.

(7) Attempt to turn liabilities into assets (for instance, screamers' nodules create very deep, throaty, resonant voices).

(8) As a parent, you remain one of the best sources of information and ideas. Avoid the double bind of feeling put upon and scorned when the professionals start asking for your opinion or angry and ignored when they don't. Dictate. Don't abdicate.

Written by a father

SECTION ONE

SOME GENERAL INFORMATION ABOUT EMOTIONAL DISORDERS

Introduction

Mental illness didn't make the list in a 1978 survey when persons living in the Roseville School District were asked to list those areas in which they felt their community had the greatest human service needs. Vandalism, drug abuse, energy conservation, public transportation, and crime were mentioned as the top priorities.

By 1983, a similar survey in the area found the need for mental health services as the third highest priority with 38 percent of the 422 persons who responded listing it as the greatest need. The only needs topping it were housing and child care services.

Does this survey measure only the feelings of one community? Or does it reflect a growing awareness of the need for better services among the population in general?

Pat Solomonson, executive director of the Mental Health Advocates Coalition, believes the latter. It's not, she said, that there is more mental illness now than ever before. Rather, according to Solomonson, more people are simply speaking up about the problem, and mental illness - while still too often accompanied by a stigma - is something whose existence within a wide variety and number of families is at last being acknowledged.

Accompanying the indications of a growing awareness of the need for help, however, are some rather dismal data about the present level of services available...especially for children. A report issued by the Children's Defense Fund (CDF) cited a 1978 study by the President's Commission on Mental Health that stated five to fifteen percent of all the nation's children and adolescents (three to nine million youngsters) are in need of some type of mental health services.

Yet, after reviewing numerous studies and reports, CDF estimates that only about one million children and adolescents - or about one-third of those who need help - are actually receiving services.

Conclusions emerging from a conference on the Status of Emotionally Disturbed Children in the State of Minnesota, held in St. Paul in 1978, also indicated grave gaps in services available to children in this state.

Responses to questionnaires completed by the parents, professionals, legislators, and other leaders present at the conference described Minnesota's programs as "too often unavailable or inconveniently located, poorly coordinated, not planned for the long-term needs of a chronically disturbed population, too expensive for many clients, and often of poor quality."

School programs were seen by the conferees as "serving a limited group and being most available in the state's metropolitan areas."

The report also concluded that though, "There is some evidence that parents are beginning to organize to seek the assistance that has not been forthcoming...the general concensus was that they are far behind other groups like the parents of the mentally retarded and learning disabled."

The CDF report made a similar observation: "The absence of respite* and support services for parents of seriously disturbed children is one of the most glaring gaps in services that we identified." (*Respite care means that the handicapped family member is temporarily cared for by someone outside his or her home, giving other family members an opportunity for a period of

relaxation.)

Finally, conferees at the 1978 St. Paul conference pointed to the absence of any centralized "clearing house" for information as a critical need that should be remedied.

Even when services might be available, in the absence of such a clearing house, parents soon learn that the right program for their child is difficult to locate.

And as the St. Paul conferees pointed out, the difficulty of agreeing on a precise definition of mental illness or emotional disturbance is a major impediment to establishing a statewide coordinated system of treatment programs. Parents, upon encountering the maze of different ideas about why their child is considered to need help and how he or she may best be treated, can easily become confused about what's best for the youngster. They question what their role should be in the whole process -- or, indeed, if they can do anything at all to stay "on top" of the situation.

Yet because of the stigma too often still attached to an emotional disturbance, the same parents have faced their own psychological barriers to forming the kinds of support groups that have been emotional lifesavers and invaluable sources of information for parents of children with other disabilities such as the Association for Retarded Citizens, United Cerebral Palsy, the Spina Bifida Association, and many others.

This booklet has been prepared in response to the needs expressed by many parents over the past three to four years in phone calls and personal conversations with PACER. They've indicated a wish to better understand the topic of mental illness and the types of treatment programs that serve children and youth and to have available the kind of information they need to make informed decisions.

As mentioned earlier, there is no true professional agreement on what a mental illness is - much less on its causes or how best to treat it. Hence, this booklet doesn't pretend to give any final answers. However, in the first section, which will deal with general questions, and in the second, which will offer specific information about programs and facilities throughout Minnesota, it's hoped readers will find some guideposts to help them through the fog.

And to end on an encouraging note...though there are many gaps in services available, there are also many fine programs in place and numerous devoted, accomplished, and caring people who staff them. Knowing the right questions to ask and some starting places to look can help you find some answers for your child or young friend.

Recommended reading

Before beginning to deal with frequently asked questions, however, three extremely helpful books about mental illness and families deserve mention. Parents who wish to seek more information in addition to that found in this booklet would find reading any of the three books time well spent. All are available through the metropolitan area library network. PACER also has copies that can be checked out by parents.

HELP FOR YOUR CHILD, A PARENTS' GUIDE TO MENTAL HEALTH SERVICES; Sharon Brehm; Prentice-Hall, Inc.; Englewood Cliffs, N.J.; 1978. This book will be frequently quoted in these pages, but contains far more factual advice than can be covered fully here. The author, a psychologist, has sought to assist parents to make the best possible use of their own expertise and to enable them to ask sensible questions. She sees parents working as partners with professionals in the helping process for their child -- once they have the knowledge needed to understand what's happening and to be able to evaluate the program(s) offered their child.

She describes the factors to apply when deciding whether professional help should be sought, lists possible kinds of facilities and types of service providers, traces the backgrounds of the various professionals, and explains what happens once contact is made with a hospital or mental health center. Types of therapy or treatment approaches are outlined, and the criteria by which parents can judge a particular program are described.

THE CARING FAMILY; Kayla F. Bernheim, Richard Lewine, and Caroline T. Beale; Random House; New York; 1982. Instead of offering factual information, this book deals with understanding what happens to a family emotionally when a member is first suspected of being disturbed and then after the suspicion is confirmed. The authors deal with the guilt feelings so many parents suffer, the pain they undergo as the acceptance of the illness deepens, the problems of dealing with the ill child's brothers and sisters, the difficulties of letting people outside the family circle know what's happening with the child, and the stress undergone by the family when trying to keep life on an even keel in the presence of the ill member. Though the book deals with emotions, it offers solid and very practical advice on how to cope with the phases mentioned above.

YOU ARE NOT ALONE, UNDERSTANDING AND DEALING WITH MENTAL ILLNESS; Clara Claiborne Park and Leon N. Shapiro, M.D.; Little, Brown, and Company; Boston; 1976. This book offers a combination of emotional and factual advice. Written by a mother in conjunction with a physician, the book also traces the progressive stages parents must follow in finding good programs: seeking help, dealing with professionals, understanding diagnoses and psychological or psychiatric terminology, and finding help within the community. Those aspects of laws that may apply to a mentally ill person and his family are covered as are the financial problems connected to mental illness. Finally, the book traces the transition of parents from passive accepters of what they're offered to active partners in the help process.

How do I know if my child might have an emotional disorder?

Among all the dilemmas facing the parent of an emotionally disturbed child, this first question - trying to decide if there is actually a real problem - may be the most troublesome of all.

Certainly, no one wishes to begin the process of seeking help for his or her child, of having the youngster labeled emotionally disturbed or mentally ill, unless there is "really" a problem.

Determining whether there is "really" a problem can, of course, be very tricky. For there may be an extremely thin line between behavior that's shown by a child going through a bad, but temporary stage that s/he'll grow out of...and one that deserves professional attention.

More than one mental health practitioner has commented that the question may be easier to handle by parents who've raised other children: the veteran parent has other youngsters around to serve as comparisons. He or she can contemplate, "Is Tom's behavior now the same way Andy acted when he was going through the 'terrible twos' and we can expect him to outgrow it also?" Or, "Is Sally going through the same thing Karen did when she was 15...or is this something more serious?"

Sharon Brehm states in her book (mentioned earlier) that there is simply no real substitute for the common sense of parental knowledge in deciding when outside help should be sought. Parents who haven't raised other children and, thus, have no basis for comparison might want to talk with someone who has had experience with "typical" child development and the variations that can be expected to occur. This can help them decide whether their child's problems are something that deserve professional attention.

Certain guidelines are also available to help parents make this kind of decision. Brehm points to three criteria to use in judging whether a child's behavior is "just normal" or a sign that the youngster needs help:

1. the DURATION of a troublesome behavior...Does it just go on and on with no sign that the child is going to outgrow it and progress to a new stage?

2. the INTENSITY of a behavior...For instance, while temper tantrums are normal in almost all children, some tantrums could be so extreme that they have a very frightening aspect and suggest that some investigation would be wise.

3. the AGE of the child...While some behavior might be quite normal for a child of two, a parent's observation of other children of their own youngster's age may lead to the conclusion that the behavior in question isn't quite "right" for their child, aged five.

Once parents have decided that their youngster's behavior does deserve at least a look by a mental health professional, the question then becomes where to turn for an evaluation.

If the child is of school age, a first step could be to approach the school's special education director and request an assessment by the school psychologist or counselor.

Should that not answer questions satisfactorily, if the family doesn't want to involve the school at this point, or if the child is not yet of school age, there are several other places to turn for an evaluation.

A family doctor may be asked for a

referral to a child or adolescent psychologist or psychiatrist. Also, many hospitals offer comprehensive diagnostic and evaluation programs. (Specific details about certain hospital programs, as well as other facilities and programs referred to here will be given in Section Two of the booklet.)

However, parents looking for services through private physicians, hospitals and other practitioners must be certain that they have ample private resources, have excellent insurance policies, are eligible for Medical Assistance , or intend to use a hospital that has Hill-Burton funds available (the latter two categories will also be explained in more detail in section two.)

Other parents, particularly those in rural areas, may want to first approach their county's public health nurse who can direct them to evaluation programs available in their area.

Community mental health centers are also a good source of help and can be less expensive than seeking out a private doctor or mental health professional.

Finally, residents of Ramsey and Hennepin Counties would want to investigate evaluation services offered through the centers run by the two counties.

What is an emotional disorder or mental illness?

Unfortunately, for the sake of anyone's peace of mind, it's something that can't be pinned down or defined precisely. For instance, we can't say with certainty that something goes wrong with the brain and then a person starts to act in a particular way. And, contrary to the way mental illness is sometimes pictured in a melodramatic movie or TV show loosely based on the theories of Sigmund Freud, it's impossible to conclude that a mother or father did something "wrong" early in the child's life and if that "certain thing" can just be uncovered and talked about, the mental illness will go away.

Most understandings of mental illnesses are based, instead of on any one precise cause, on a description of how the affected person behaves and relates to others.

The child judged to be disturbed or troubled is probably not going to do anything that other children don't. It's simply that his/her inappropriate behavior will be seen more often or s/he will misbehave in more extreme ways. Parents are in a good position to judge when their child's behavior has gone beyond the realm of what all children do at one time or another and into the world of illness.

Different professionals look at emotional disturbances in different ways. Their outlook - and their treatment plan - is usually shaped by their training and their philosophy about the origins of mental illnesses.

Though a "philosophy" may seem like a pretty fancy topic to sit around discussing by parents who're frantically seeking a way to get their child to stop terrorizing other neighborhood children, it's still recommended that parents discuss this with the professional they contact. Since the treatment program for the youngster will stem from the professional's philosophy, parents should be sure they agree with "where the professional's coming from." Otherwise, their cooperation in the treatment process may be limited and hurt its chances of success.

When seeking a treatment program for their child, parents may also want to seek a "second opinion" if they disagree with the approach suggested by the first mental health professional.

The CDF report outlines several treatment philosophies that are common in programs throughout the United States today:

1. The "psychodynamic view" sees a child's problems as resulting from psychological conflicts within the child and believes that changing the way children think or feel about themselves will change their behavior. Treatment would rely generally on verbal therapy (individual talk sessions with a therapist) or play therapy (where important dimensions of a child's personality are revealed and dealt with in play activities in the therapist's office).

2. In "behavioral" therapy, problems are thought to occur because children have been previously rewarded for their problem behavior (for instance, a child might receive the attention he wants only when he is very naughty.) Therapy based on this philosophy involves changing the pattern of rewards and punishments children receive from their surroundings so that their behavior will change. Parents would be closely involved in this kind of therapy.

3. The "ecological view" reflects a belief that helping children goes beyond the first two approaches described above. This philosophy sees children as

part of a larger community (that is, their family, their class at school, their neighborhood friends) that must be understood and often restructured to encourage their growth. Therapy involves working with all the important people in the group where the problems occur (not just his parents). The focus is on what's happening in one of these social systems at the present time, not on what might have happened in the past, and on dealing with present difficulties.

4. Children being treated under the "physiological model" or the "medical model" philosophy would have been diagnosed as having a specific "illness" or a symptom pattern that might be suppressed by appropriate medication. A treatment program would involve medical practitioners such as psychiatrists, who have medical degrees, or pediatric neurologists.

Parents should be aware that programs in this category may be the most likely to be eligible for insurance coverage and Medical Assistance because they relate to diagnosis by a psychiatrist and are conducted or supervised by medical personnel and, often, may be connected to hospitals. Less likely to be eligible for coverage are programs conducted by "non-medical" personnel.

Finally, treatment programs based on this philosophy may involve medication of a youngster. The focus of treatment would be on the child's "illness" and less on the family's structure and pattern of behavior as a possible cause of the problem.

In all of the four approaches just described above, teams of physicians, psychologists, social workers, and educators may be involved and working in cooperation.

What types of programs should I be looking for or considering?

As mentioned earlier, there will be a listing in the second section of many specific programs that are available to Minnesotans.

However, an outline of the general kinds of services may be helpful at this point.

Among NON-RESIDENTIAL PROGRAMS, the following levels of service may be found:

1. Early intervention efforts - these could include providing parents with counseling (without necessarily involving the child); offering programs that help children cope with a crisis (such as the loss of a family member to death or divorce); providing preschool special education classes; or serving as a "hotline" where parents could call for support or advice.

2. Outpatient therapy - in these programs (which reach more children than any other level of program), a child would continue to live at home but come to a facility or a psychiatrist, psychologist, or social worker in private practice for perhaps an hour or two each week for counseling sessions. Outpatient therapy might be given to a child alone (individual therapy), to a child as part of a group of children with related problems (group therapy), or to a family as a whole (family therapy).

3. Intensive services in the home or community - these programs are often called day treatment programs. Through them, children remain in their homes but may spend most of each day in a therapy program, where treatment of their illness is combined with their academic program and recreational activities. Families may also be involved in the program, meeting with therapists to learn to cope with the child at home or to perhaps change certain ways in which the family functions.

RESIDENTIAL PROGRAMS include inpatient care of the child in psychiatric hospitals, the psychiatric units of general hospitals, or specialized care in residential treatment centers. These programs are generally reserved for seriously ill children whose functioning in their own homes and relationships with other family members have become impossible.

Another arrangement for service might be provided through FOSTER CARE. Parents who have come to feel incapable of coping with a disturbed child in their own home can seek through their county's human or social services department to voluntarily place the youngster in a foster home. This can be done in Minnesota without giving up parental custody of the child. Under this arrangement, the child could receive professional help for his/her emotional disability and still remain in a home setting - though not his/her own.

Vountary placement in a foster care setting cannot take place unless the county social or human services department believes that there is a genuine and well documented need for the child to leave his parental home. The maximum length of time that a voluntarily placed child can stay in the foster home arrangement is 18 months. An extension beyond that time would require the case to go before a juvenile court. Also, before agreeing to a voluntary placement, counties attempt to work with the parents and enable them to keep the child in his/her own home.

What are the different kinds of mental health professionals?

A psychiatrist is a person who has completed medical training and received a regular medical degree (just like your family doctor). He or she then went on to take specialized and advanced training in psychiatry - the medical study, diagnosis, and treatment of mental illnesses. Because of the medical degree a psychiatrist is qualified and licensed to prescribe medication for his patients.

A second mental health professional is a psychologist; he or she does not have a medical degree and cannot prescribe medication. However, both a "licensed consulting psychologist" and a "licensed psychologist," professional titles used in Minnesota, have completed advanced studies in human behavior and are qualified to evaluate and assess a child and conduct therapy programs.

To become a "licensed consulting psychologist", a person must complete a PhD program in psychology, have at least two years of post doctoral experience in the field of psychology, and pass both written and oral tests required by Minnesota's licensing board.

To become a "licensed psychologist" a person must have a master's degree in psychology, have at least two years of experience in the field, and pass a written test required by the licensing board.

Parents should be aware that programs staffed or administered by the professionals described above are the most likely to be eligible for insurance reimbursement and for Medical Assistance.

Social workers can also serve as mental health professionals. They're persons who've studied in human-service-related fields, and they staff many of the community-based programs in Minnesota. Though they're not licensed as medical practitioners, they do often conduct therapy sessions and also coordinate efforts that bring together the child, his family, his school, and other important persons in his life.

Psychiatric nurses are RN's (registered nurses) who've taken further studies in the field of psychiatry. They often work closely with a psychiatrist, supplementing the services he or she is able to offer directly.

Special education teachers are also active throughout the state in working with children who are classified as having "emotional/behavior disorders" (the term used in Minnesota's educational system.) Their special role will be described in the section on "What Help Can We Expect from the School District for our Child?"

There are many other types of professionals staffing the various programs throughout the state, and they go by many assorted titles. Rather than attempting to list and define them all here, parents are advised - at the first meeting at a facility they've contacted - to discuss the backgrounds of the staff members and find out more about the individual qualifications of the people who will be working with their child. It will be the parents who make the final judgement as to whether they think the staff has the qualifications to offer a purposeful and helpful program for their youngster.

A word of caution, however. While one may be tempted to judge most favorably those programs with the most academic

degrees hanging on the wall, one director of a local residential treatment center says he does not hire on the basis of "degrees" but looks simply for people with compassion, empathy, and proven experience in working with troubled youngsters...and his center has reportedly produced some fine results with children whom hospital-based programs have failed to help.

Another important question to be considered when deciding on a program for a child involves the use of medications as part of his/her therapy plan. A good deal of controversy surrounds the question of whether various drugs are effective in treating emotional disorders.

Some programs try to keep any medication at a minimum, believing that the long term answer to their patient's problem lies in changing behaviors and attitude and self images through talk or play therapy.

However, many parents as well as professionals will attest to good effects from their child's receiving medication as part of the treatment process.

The final answer may be decades away. What is important to recognize at this point is that parents who believe medication should be at least considered for their youngster will need to find a program that is connected to a psychiatrist. The parent who has strong beliefs - either pro or con - about medication should discus the issue thoroughly with a service provider before the child begins a program.

You've talked about different kinds of programs and 'therapies.' What are the different kinds of therapies?

Once again, Sharon Brehm's book is excellent in its description of various approaches to the treatment of mental illness. PSYCHOTHERAPY, a broad term, includes those kinds of treatment where the goal is actually to change a child's personality - rather than simply his or her outward behavior.

This might be done through "psychoanalysis", a course of treatment where the child is worked with on an individual basis. In psychoanalysis, the therapist attempts to bring an unconscious conflict to his patient's awareness and then help him or her deal with the conflict.

A second type of psychotherapy, "interpersonal therapy," is based on a belief that problems arise from difficulties the individual has relating to other people. It helps patients - through individual counseling combined with group sessions - to understand their present relationships and how to establish new and satisfactory ones.

A third type, "client centered therapy", holds that people have problems because they're not able to be their true selves, that they act unnaturally or in conflict with their internal wishes because of external pressure. This kind of therapy tries to help the child become his or her own person.

Rather than focusing on a problem's origin and seeking to change personality, BEHAVIOR THERAPY concentrates on a child's outward behavior and seeks to change those aspects of it that are inappropriate or produce negative results. Typically, behavior therapy programs are designed to take less time than are those that seek to produce underlying personality changes.

Therapy programs can take several forms. For instance, a child might meet individually with his or her therapist for talk sessions. Or young children might engage in play therapy where it's hoped they'll reveal feelings and conflicts through play situations. A family might be asked to meet with a therapist as a unit so that problems with the family's functioning and relationships to each other could be worked through. Finally, a child might meet for group therapy with other children who are experiencing similar emotional or behavior problems.

Other types of therapy approaches include: "desensitization therapy" where a child who has excessive fears is gradually exposed to the object of his fear while in the presence of, and receiving the support of, a trained professional and "parent effectiveness" counseling where parents are taught techniques to improve their relationship and dealings with a disturbed child.

Finally, certain parents may conclude that their family functions well as a unit, that the manner in which they relate to their children has not led to problems for the siblings of the disturbed child, and, therefore, that the root of the troubled youngster's illness rests with a cause - possibly unknown - other than his/her family relationships.

Such parents may wish to seek out a "supportive therapy" group; this kind of group seeks simply to help parents and siblings cope with an ill family member and keep stress at a minimum. The focus of "supportive therapy" groups is not on the parents' actions as a possible original cause of the youngster's difficulty.

What help can we expect from the school district for our child?

To begin to answer this complex question, let's first look at a federal law called Public Law 94-142, The Education for All Handicapped Children act. This law and its regulations specify those special educational programs that must be provided for handicapped students by their school districts. PL94-142 also defines "related services," those services that a school must provide for a child so that he or she can benefit from his or her special education program.

Included on the list of related services are both "psychological services" and "medical and counseling services." "Medical services", however, must be provided only for diagnostic and evaluation purposes.

The "psychological services" that a school must provide are defined as:

i. "administering psychological and educational tests, and other assessment procedures;"

ii. "interpreting assessment results;"

iii. "obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;"

iv. "consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and"

v. "planning and maintaining a program of psychological services, including psychological counseling for children and parents."

Parents interested in the ways in which a school psychologist may be expected to serve their child should keep the above list in mind. It's usually interpreted to mean that school psychologists would not provide the kind of therapy program for a child that we would see in a psychiatrist's office, mental health clinic, or in other programs operated by mental health professionals outside the school.

Psychotherapy or individualized psychological treatment traditionally is not considered a related service - even though that kind of treatment program may be necessary as a part of a child's total program.

Accordingly, in Minnesota, the provision of psychotherapy or the kind of treatment programs that psychiatrists, licensed psychologists, or licensed consulting psychologists conduct is not considered a school district's responsibility because these are considered "medical" rather than "educational" services, according to personnel from the Minnesota Department of Education.

The school psychologist is usually seen as a test administrator or an evaluator and as a person who counsels and assists in the management of a child's behavior while s/he is in school. The school psychologist does not function as the child's "therapist."

Teachers, trained in teaching emotionally disturbed youngsters, also do not pretend to serve as psychotherapists or providers of treatment designed to deal with deep-seated disorders.

Rather, their basic role, as described by a consultant with the Minnesota Department of Education, is to help design or provide instruction, case

management, and support to an emotionally disturbed child within the educational setting which accommodates his or her emotional problems.

The teacher must know how to shape the educational environment so that it's most conducive to the child's academic and social progress. Finally, the teacher will use certain techniques designed to help the child's outward behavior become more productive, less destructive, and more likely to result in positive relationships with his peers.

The Minnesota Department of Education explains a school's responsibility as follows: A district is responsible for determining whether a student is educationally handicapped because of the child's emotional/behavior problems. The determination may include a psychiatric or psychological evaluation conducted at a hospital or treatment center as well as behavior and educational assessments conducted by the school. Based on this information, the school needs to develop an IEP that would include academic, behavioral, and social goals and objectives and may include "counseling" as a related service.

Such counseling might be provided by a school psychologist, counselor, social worker, or teacher, and would usually be less intensive than that provided by a psychotherapist.

The State Department suggests that school districts would not be responsible for the therapy provided by a treatment center, hospital, doctor or other mental health agency outside the school unless the school had contracted with such persons to deliver the "related services" specified in the student's IEP. Most treatment programs in hospitals or clinics are not part of the child's educational program, according to the Department.

Schools are responsible for providing appropriate educational services for children who have emotional disorders and behavior problems. This would mean establishing a full "continuum" of educational programs within its system. The continuum would offer arrangements ranging from placement in a regular classroom with consultation provided to the classroom teacher to a fulltime special education classroom for emotionally disturbed children. Often, small or rural districts work in cooperation with neighboring districts to develop the full continuum of services.

The types of placement called for by the full "continuum" requirement are known in Minnesota as "levels" of service.

When a district has the full continuum in place and if the child's emotional disturbance is so severe that s/he cannot function in any of the school's settings, the State Department suggests that consideration be given to placing the child in a residential facility where s/he could receive both an educational program as well as needed treatment.

The Department emphasized, however, that such placements are usually made for "treatment" reasons, not because of the child's educational needs. Therefore, when a child is placed for treatment, the school district's responsibility would extend only to paying for the educational services for the child and not for the financial costs of the child's board and room and treatment for the emotional problem.

The latter costs, as viewed by school districts, should be born by the child's parents, insurance companies, county social service departments - or any combination of the three. (In those situations, however, where the school is making the placement for educational reasons, the school would be responsible for assuring that the education, board and lodging, and transportation would be provided at no cost to the parent.)

To summarize, there are clearly several

strong but conflicting forces in operation here:

Parents, understandably, can argue that if their child needs psychotherapy or another type of intensive therapy in order to learn, then that therapy should qualify as a related service which the school must provide. Or if the student needs placement in a residential facility in order to progress academically, then the costs of placement should be the school's.

Schools, understandably, suggest that psychotherapy or other types of intensive therapies are not "educational" but rather are "medical" treatment. Therefore, the schools believe that they should not be required to deliver those services. Schools further suggest that such responsibility should not be placed on them without changes in laws that more clearly identify such services as the school's responsibility and provide the needed funds from the federal or state levels or other sources to cover the costs of such services.

The courts are beginning to address this issue as well....with somewhat mixed results. Hence, the exact responsibility of a school district for the provision of psychological services is far from finally resolved. As a practical matter, however, parents at this time should realistically expect that if their child's emotional problems are severe and the school district has tried various settings and programs for the youngster without much success, they will need to seek help outside the school system. They would also need to seek financing of that help from insurance policies, social service financial assistance programs, and/or their own pockets.

Let's look next at what a school district may be expected to offer its students with emotional/behavior disorders.

To begin, consider first the guidelines for "Defining and Serving Students with Emotional/Behavior Disorders." (Guidelines do not have the force of law in Minnesota as do statutes and the State Board of Education rules. Instead, the guidlines offer suggestions by the Minnesota Department of Education on how individual schools might wish to proceed in various areas. They are an attempt to bring consistency to practices throughout the state. However, parents will want to be aware that individual school districts may have different criteria for entrance into their programs for students with emotional/behavior disorders.)

In order for a child to enter a school's program for students with emotional/behavior disorders, the handbook recommends that an evaluation team must find that the child's behavior:

1. has not been changed/improved by at least two planned and documented interventions applied in the school setting;

2. occurs in more than one setting under school jurisdiction;

3. greatly interferes with the student's or other students' academic/social/emotional growth;

4. is chronic (continuing over a long period of time) and intense (characterized by high frequency, long duration, and/or high strength; and

5. is characterized by one of the following five behavior criteria:

    a. inability to build or maintain satisfactory interpersonal relations with peers, teachers, and/or school personnel,

    b. a general pervasive mood of unhappiness or depression, wide mood swings,

c. the development of a variety of physical symptoms or fears associated with personal or school problems,

d. inappropriate behaviors or feelings under normal circumstances,

e. inability (underachievement) to learn, given adequate educational opportunities that cannot be explained by intellectual, sensory, health, cultural, or linguistic factors.

The handbook further advises that no student shall be identified or assigned to a program for students with emotional/behavior disorders for disciplinary reasons only.

For children under five who haven't yet been in an educational setting, the handbook acknowledges that the criteria above cannot be strictly applied and recommends instead that "developmental norms and parental expectations" should be considered when assessing the younger children. The guidelines suggest that the assessment process should decide if a given behavior handicaps the child because it's "developmentally inappropriate, persistent, and resistant to change."

If a child has entered a special education classroom for emotionally disturbed students, he or she may expect to find a classroom teacher who attempts to shape the classroom environment so it produces as few stressful situations as possible. The teacher will also probably use a combination of teaching techniques known as behavior modification or behavior management. Shelves of books have been written on this topic, making a complete description of it impossible here. However, a few examples follow to give parents a suggestion of what's involved.

The teacher might reduce stress by trying to prevent the likelihood of inappropriate behavior; to do this, she'll clearly state a few clear cut expectations of the child and then enforce them consistently. Before certain behaviors might occur, she'll make sure the child understands what their consequences would be. She keeps the classroom rules and procedures simple and consistent.

The teacher may establish with the student certain nonverbal signals that will be used to clue him/her in that his/her behavior's about to become unacceptable. She may anticipate a problem and quietly switch the student to another task for awhile. She will have met individually with the youngster to discuss conflicts s/he has with behavior and methods that could be used to forestall problems. When such a problem does seem likely to happen, she may intercede by offering quiet support and nonverbal signals to remind the student of the methods they'd discussed to handle the problem.

Frequently, a reward system will be used; for instance, a student might know that if s/he gets through a given class period without banging his/her desk top in anger, s/he will earn a certain number of points that could be used at the week's end for extra gym privileges.

A classroom for disturbed youngsters may also contain a private space (often called a "time out" room) that can be used for "cooling off" periods by students who've temporarily lost their self control.

Whatever the variety of techniques used, they will typically deal with students' outward behaviors.

As such, for many seriously disturbed youngsters, behavior management or modification techniques may not be the complete solution to serve the child's needs. Accordingly, it's expected that many deeply troubled youngsters, even though they can function well enough to remain in the group setting of the special education classroom, will also need to work with an outside psychologist or psychiatrist.

One school district's program

To better understand what a school can offer, the following is a picture of the program offered through one local suburban school district. While certainly not typical or identical to what may be available at schools statewide, the program does give a glimpse of what's at least possible.

When visited, the district's Level V program for elementary children with emotional/behavior disorders had eight children, all boys, ranging in age from eight to thirteen.

The teacher, who has a master's degree in special education and is licensed to teach emotionally disturbed children, was assisted by one fulltime aide.

The total classroom environment was very structured, the teacher explained, since emotionally disturbed youngsters find it especially hard to adjust to change. Hence, she lets them know as clearly as possible what's expected of them and tries to make sure her policies and rules are as consistent as is humanly possible.

She uses combinations of the techniques described above and considers the awarding of points extremely important. The points are given for getting and staying ready for tasks, following directions, completing work, and being cooperative with the teacher and other students. Students are awarded points immediately after each class period -- the awarding has to take place quickly so good behavior can be reinforced. Thus, on occasions when points aren't given, the child can easily remember the exact behavior that led to the missing award.

Students are able to use the points for some tangible goods (like posters) but - more frequently - for non-material rewards: more free time, going to the gym, listening to records, and flying kites for instance. Each student decides weekly on a specific goal to work on in order to improve his/her behavior.

When students find they can't keep control of themselves temporarily, there's a spot in the classroom where they can stay for awhile or another, more isolated space across the hall where an adult will go with them and stay until control is regained. She says that teachers of emotionally disturbed students do have to know how to gently, but firmly, physically restrain those in their charge when it's necessary to protect the child and others around him.

Knowing the children as individuals is important in many ways, she emphasizes. For one thing, ignoring the negative behavior of one child can lead to its decrease since s/he's no longer receiving attention for it. For another child, the teacher points out, ignoring bad behavior may only mean he'll escalate it in order to force someone to pay attention. Hence, methods and procedures used in the classroom must be planned on an individual basis for each child.

The teacher says that the students making the most progress in her classroom are those counseled by an outside psychologist or psychiatrist or those whose families are receiving counseling. She will seek permission from those children's parents to talk to the child's therapist on an ongoing basis - to discuss the goals being worked on in the child's therapy so she can work toward the same goals in her classroom when possible.

Close involvement with parents is also sought, she says, since children also make the most progress when their home and school are working together.

The Level V program at this school asks that parents of the students meet monthly with the teacher and another school professional who's not working

directly with the child. They discuss mutual behavioral goals that home and school are working on. Also, a note is sent home daily if a child has had a good day at school. Parents are requested to spend fifteen minutes of time on an individual basis with the child each day to reinforce their youngsters' good days at school and to attend "parenting effectiveness" classes in the area.

Among the children present in early spring, some have been in the classroom since September and not mainstreamed for even one class period. Others who began in September have since been mainstreamed for up to six classes, still returning to the classroom for students with emotional/behavior disorders (E/BD) for short periods.

The whole point of the program, states the teacher, is to move children back into the mainstream - when they're ready. The point system is used to measure their readiness. Students must have a certain number of "good" days (what their behavior must be like in order to qualify as a good day is discussed with each child in advance) before they'll be mainstreamed for the first class. The teacher will continue to monitor how the student is doing in the class outside her room. Should all go well and the student continue to accumulate more points and good days, further mainstreaming can take place.

Not only is there emphasis on enabling children to leave the special classroom and the self-contained situation, the children won't have been placed there without a good deal of thought in the first place, explained the school district's coordinator of programs for emotionally disturbed students. Every attempt is made to serve students in the least restrictive setting before referral is made to a Level V program.

At the other end of the district's continuum of services, students in Level II would be in a regular classroom. A special education teacher would work with the youngster's classroom teacher, making suggestions for room arrangements that might reduce potential problems or offering ideas on how to improve the student's self image in the classroom. Contracts or management systems may be carried out through joint efforts of regular and special education staff.

Students in Level III would be in regular classes but also work directly with a special education teacher, meeting daily to discuss their behavior and developing strategies to cope with problems. The students might also meet in small groups to work on behavior in social situations.

Level IV students would have a program similar to that of Level III youngsters but might also need to spend additional time in a resource room and would require much more involvement from the special education teacher in their whole program.

Only when a student has failed to make progress in any of the less restrictive levels would he or she enter the Level V classroom, noted the coordinator. "We have all sorts of gates that must be passed before placing a child in Level V. It's not something we do lightly."

The coordinator's remarks supported the teacher's emphasis on the need for parental involvement as she stressed that children are most likely to get better when their families are working with the school to provide a healthy atmosphere.

"Kids often are in trouble because of what's happening at home, and the school can't be helpful unless we know what's going on. Also, parents have every right to know and need to know what the school is doing, what strategies we're using. There must be good cooperation and follow through," concluded the consultant.

SECONDARY PROGRAM

Secondary students with emotional or behavior disorders, although not in a

self-contained classroom for their entire school day, would also have the "continuum" of programs available to them in this district.

Those with less severe problems would remain in their regular school environment where they would meet and receive academic credit for participating in counseling with a staff person trained in working with emotionally disturbed students. Contracts would be drawn up between the student and his or her staff counselor, outlining the behavior goals towards which the student would work.

Continuing sessions with the student's counselor might be on an individual basis, or s/he could work with the counselor as part of a group. The sessions could be devoted to "therapeutic conversation," i.e., discussions that focus on problems the student is encountering, what things about his/her behavior could be leading or contributing to the problems, and what s/he can do to lessen the problems.

High school students in this school district who have more severe emotional disorders would enter a Level V program at a special education cooperative school to which the local district belongs.

Students in the Level V program would have a rotating class schedule, going to different rooms for each of their academic subjects just as their nonhandicapped peers do. However, each of their teachers has dual certification or a background in both an academic area and in teaching emotionally disturbed students. Special staff members for the program include a licensed psychologist and social workers.

Each student has a "case manager" assigned to him/her, and s/he would meet with that staff member in the morning and afternoon. The case manager has primary responsibility for observing and guiding the student's progress.

The program at the special education cooperative places less emphasis on behavior modification techniques such as those discussed in the local district's program for elementary youngsters. Rather, according to the program's director, the approach here is "psychoeducational," an approach that deals with the students' personalities and helps them make the inward changes necessary to eliminate their self-defeating and negative behavior patterns.

Students would meet for counseling, on a group or individual basis, either daily or less frequently according to their individual needs. They're encouraged to work with an outside professional in addition to the school program.

What's my role as a parent in the midst of all the professionals who might be working with my child?

Like children with all handicaps, an emotionally disturbed youngster is probably going to have more than one professional involved in his life.

And like parents of all handicapped children, one of your major roles will be to coordinate the services received by your child. Yours will be the continuing presence in his or her life; while others pass in and out of his existence, you'll be the person who remembers what has happened during the course of his lifetime. In an ideal world, we would hope that professionals from various "agencies" (like a school or mental health center) would be talking to each other on a regular basis and exchanging information on what's happening with a person in their care and what each agency might be doing to help the efforts of the other(s).

In real life, however, there may be a breakdown in communication - therefore, it may become necessary for you to serve as the link between service providers.

Most often you will find that the child's progress can be helped when all services providers - educational, emotional, and medical - are aware of what each is doing to help. If you find that the professionals appear to be working in isolation - or even against each other - you may wish to request a staffing with representatives present from the school staff, from each outside agency, and possibly from a parent advocacy organization so that communication lines can be opened and efforts coordinated.

You will also need to monitor the program offered by the school district and be sure that it does have in place a "continuum" of services like that explored earlier in the local suburban district.

A district that seems to offer nothing except the provision of occasional counseling periods for the student or a recommendation that he or she be placed outside the home in a residential treatment center should be viewed with concern. In such a case, the parent would then need to urge the creation of a program that does meet the needs of an emotionally disturbed child through his home district, keeping in mind the various levels of programs described earlier that schools are required by law to provide.

'Who Do We Blame? What Good Does It Do?'

by Barry Haddle

It seems to be an ingrained part of human nature to look for someone to blame whenever anything goes wrong. This is especially true whenever something goes wrong with a child. Parents blame teachers, teachers blame parents, and they both blame administrators. Even if it were possible to establish blame, what good would it do the child?

The people who suffer most from this blame seeking are the parents of children with emotional and behavior disorders.

Whenever a child has an obvious physical handicap, very few people are insensitive enough to suggest that the parents are at fault. No one says to the parents of a blind child, "If you had raised him properly, he would not be blind." Most people would have more respect for the feelings of the parents of a severely retarded child than to blame the parents for their child's affliction.

We have compassion for these parents and their children. We try to help if we can. The parents of children with mental and emotional handicaps, however, are fair game for all. They must listen to remarks such as: "If he were my child, I'd make him listen!" "The only thing that girl needs is a good spanking!" "He's just lazy, you've got to make him learn!" "What kind of parents would raise a kid like that?" and so on. I'm certain that many more examples could be given by parents who have been victims of such cutting remarks.

Consider the plight of these parents. They often blame themselves. Consumed with guilt, they ask themselves, "What have I done wrong?". In desperation, they seek help from "professionals." They go from agency to agency, all professing to help troubled children. They read book after book written by "experts." They receive counseling and attend seminars. Many spend their savings in a fruitless effort to "find a cure." A few lucky ones do get help, but the success rate is dismally low. For the unlucky majority, the feeling of hopelessness increases as they see little improvement despite all their efforts. Many see a future full of heartache and little hope.

These parents do not need the additional punishment brought on by callous remarks made by others.

The blame-seekers never explain how parents of troubled children can also have "good" children in the same family, nor how some lazy, lawless and otherwise unfit parents can have "good" children. If the parents were always to blame, this would never happen.

Rather than looking for someone to blame, we should all work together to see that the necessary resources are allocated to conduct research and find solutions to these problems. I do not mean that we need more people to invent half-baked theories so that they can write books and conduct lectures. These do nothing more than enrich authors by preying on the desperation of parents willing to try anything.

We need legitimate research by scientists. We need answers about how the mind really works and how it is influenced by body chemistry. Such research, of course, is being done, but not on a scale that bears any relationship to the magnitude of the problem. We need a research program to improve the quality of human life that has the scope of the Manhattan Project.

The whole country would benefit and many presently unhappy parents and children would be eternally grateful.

(Mr. Haddle, the author of this article, is principal of the Ferndale Elementary School in Johnstown, Pennsylvania, and is in charge of special education for the Ferndale area. "Who Do We Blame? What Good Does It Do?" was reprinted by permission from the Exceptional Parent magazine. It appeared in the magazine's December, 1982, issue. No further reproduction is allowed without express permission from the magazine.)

THE EXCEPTIONAL PARENT magazine has served parents and professionals concerned with the care of children with all handicapping conditions (mental, physical, emotional, and learning) since 1971. Yearly subscriptions (eight issues) are available at $16.00 for individuals and $24.00 for organizations, schools, and libraries. To order, write to THE EXCEPTIONAL PARENT, 605 Commonwealth Ave., Boston, MA. 02215, giving your name and address along with the information that you would like a subscription.

SECTION TWO

SERVICES AND PROGRAMS IN MINNESOTA

When using this section, three understandings should be kept in mind:

1. Programs and services are always in a state of flux. In certain cases, a service that existed when this book was researched may have been dropped or changed in form. However, by calling the numbers listed, you will have a starting point in locating a service even though its exact form may have changed.

2. In listing and describing programs and services, PACER did not have the resources to individually evaluate and approve each one included in the following pages. However, the listing is limited to services connected with some type of established institution (a county or hospital, for instance) and, therefore, subject to some sort of public scrutiny, monitoring requirements, and/or monitoring.

3. This booklet concentrates on "public" programs or services (those connected with county human services departments, for instance) since they are more likely to be of help to limited-income families. Besides such programs, there are, of course, many privately-operated services or facilities located in the metropolitan area. A starting point in locating them is to contact the Minnesota Psychological Association or the Hennepin or Ramsey County Medical Societies (described on page 33), or your private physician.

To locate privately-operated services/programs outside the metropolitan area, you may wish to contact your county nurse, family doctor, or the Minnesota Psychological Association.

Also, a list that includes many "private sector" facilities is available through the Minnesota Department of Human Services, Mental Illness Program Division, Centennial Building, St. Paul, MN. 55155, (612) 296-4497. Write or call and ask for the Division's list of what are called "Rule 29" facilities. These are programs that offer outpatient services.

A variety of available programs

In the following pages, you'll find many different types of programs and services described: hospital-based programs, community mental health centers, services offered through Ramsey and Hennepin Counties, the University of Minnesota hospital, and residential treatment centers.

In addition to the facilities and programs described in the following pages, parents may wish to consult mental health professionals who are in private practice.

The Minnesota Psychological Association (MPA) conducts a free, statewide referral service that helps people locate an appropriate psychologist. By calling (612) 920-2998 and asking for the referral service, parents could learn of licensed psychologists in their areas with skills related to their child's requirements.

Persons in the metropolitan area could contact the Ramsey County Medical Society (612-291-1981) or the Hennepin County Medical Society (612-623-3030) to receive the names of psychiatrists. Neither Society would actually rate doctors or recommend one particular psychiatrist. However, they will let callers know which psychiatrist(s) is closest to their geographical area. Also, they will tell callers whether or not the doctor in question is board certified.

Some financial considerations

None of the programs or services is free. Hence, unless your private funds are unlimited or you have a marvelous insurance policy, other financial sources must be sought. Because each person's financial situation, each insurance policy, and each treatment program's eligibility are somewhat unique, once again no hard and fast answers can be given that will apply to each specific situation. Here, however, are some financial suggestions and some pitfalls to avoid.

Insurance policies

Group health policies written under Minnesota law for groups composed of Minnesota residents must provide for mental health coverage. Generally, they will at least partially cover the costs of treatment through a hospital program, a community mental health center, a residential treatment center, or a psychiatrist or licensed consulting psychologist.

However, because of certain "fine print" complications, some group policies may not have been written under Minnesota law and, therefore, may not contain the mental health coverage. Hence, before committing yourself to an expensive treatment program for a family member, make absolutely certain that your policy does have the coverage needed. (Questions about specific Minnesota legal provisions regarding insurance policies may be addressed to the Department of Commerce, Enforcement Section, 500 Metro Square Building, St. Paul, MN. 55101.)

Policies written for individuals (non-group coverage) may vary a great deal - their specific provisions should always be examined.

Finally, even though you know you have the insurance coverage in general, the therapy or treatment program you're considering should be checked out to make sure it's eligible. A rule of thumb is that the more medically-

oriented a program is, the more likely its eligibility. Programs conducted by psychiatrists or licensed consulting psychologists have better chances for insurance reimbursement than ones run, for instance, by social workers with bachelor degrees. Also, programs operated by hospitals, even though they don't require hospitalization of the child served, may be eligible.

As you'll note when reading the section on Mental Health Centers and counties' mental health programs, some are eligible for insurance coverage. This topic should be explored during an initial meeting with the county or center. Also, you may contact the State Department of Human Services for a list of the Centers and county programs that are eligible for insurance coverage.

Hill Burton funds

Under a federal law, hospitals that received federal funding for building or rennovation are required to "pay back" part of their obligation to the government by "writing off" part or all of the costs of care to families whose incomes are limited and who are receiving no other government aid. A few of the Twin Cities area hospitals have some of these funds available; those that do are noted accordingly in the section on hospital-based programs. This possibility should be explored by families with limited incomes. To do so, direct an inquiry to the hospital's business office.

Medical Assistance

Suppose that your family's income is high enough to exclude you from receiving any kind of government income assistance - but too low to handle the costs of medical care for an emotionally ill youngster.

You might want to find out if your child could qualify - not for an income assistance program - but for Medical Assistance (Medicaid) to help handle the costs of his/her necessary treatment. Though it's the child's costs that are a concern, it is the parent's income that is taken into account when determining eligibility. Find out if this is a possibility by inquiring through your county's Human or Social Service Departmnt.

What kind of programs might be covered under Medical Assistance? The general guideline is those most medically oriented; i.e. most hospital-based programs, some - but not all - community mental health programs, and services from private doctors.

Currently, the types of programs that can be covered are in a state of change. Courts are re-examining the eligibility of certain programs, and the federal administration has granted certain waivers that allow some programs to receive Medicaid reimbursement now that would not have been eligible in the past. Therefore, it is always a good idea to check in advance whether or not the program in which you're interested might be, or might become, a Medicaid-enrolled provider.

Sliding scale arrangements

Surprisingly, a few private programs (those not operated by counties or the state) do have fee scales that are adjusted according to your ability to pay (sliding scales). Frequently, they receive government or United Way funds that enable them to use the sliding scale schedule.

Usually, however, you'll find sliding scale arrangements in connection with "public" programs (those connected with or supported by the government). This category would include care at the University of Minnesota hospital, a community mental health center, in a state hospital, in residential treatment centers, through voluntary social service agencies, or through programs with which Hennepin and Ramsey Counties and others have contracts for provision of service.

Understandably, parents with limited incomes or without ample insurance - but unable to qualify for Medical Assistance - will most likely find help for their youngster in one of the programs described in the previous paragraph.

Mental health programs offered by Minnesota counties

Many parents with limited resources will find the mental health program operated by their county a wise spot to contact in seeking services for an emotionally disturbed child.

The counties' obligation to serve families with limited incomes stems from the Community Social Services Act (CSSA), which grants a combination of federal and state funds to each Minnesota county to provide services for certain groups of people, including emotionally disturbed children and adolescents. Counties must match, from their own funds, the state's portion of the grant.

This money is then used to provide care, either through a mental health program the county runs itself or through a local community mental health center, for children whose parents cannot afford, or whose insurance doesn't cover, the full costs of services. (Parents will be asked to pay for as much of the care as their income and insurance allow.)

Services through most community mental health centers and certain of the programs operated by counties themselves can be covered by insurance policies (i.e., the eligible centers have been approved as "rule 29" facilities by the state's Department of Human Services).

Services from such centers may also be covered by Medical Assistance, also known as Medicaid. However, being approved as a "rule 29" facility does not guarantee that the center will be covered by Medicaid.

Once again, parents can check with the Department of Human Services to determine whether or not the mental health program run by their county is eligible for insurance and/or Medicaid coverage.

Parents approaching one of the centers for services, then, should expect that some assistance will be available from the county if their own income is limited. However, they will also be asked to contribute a certain portion privately if possible, and any insurance they have could be used as would be Medical Assistance if they and the program are both eligible for it.

Because the CSSA is somewhat vague and says only that each county must "address" the needs of groups such as emotionally disturbed youngsters, services vary widely from one center or county to another. Within Minnesota, some urban counties are operating their own comprehensive and extensive programs. Many other counties belong to a mental health center along with several others. Yet others may be "going it on their own," contracting with private practitioners to provide services and referring persons in need of hospitalization to large hospitals outside their own area.

Typically, we can expect that a county will have contracted with or arranged with a residential treatment center to provide long term residential care for youngsters who can not remain in their own homes.

Finally, some counties will also have in-home services and/or foster care provisions in place for emotionally disturbed youngsters whose families are experiencing difficulties but for whose children placement in a group home or residential treatment facility is not recommended or required.

Parents who are interested in the types

of services provided in their county would be interested in the Community Social Services Act (CSSA) plan each county must develop to show how it provides care. The plan has to be on display at the government center or courthouse, and parents could ask to see it. The plan must be updated every two years; a notice of the planning process that accompanies the update must be published and parents could use this process to offer their own input.

The Minnesota Department of Human Services maintains an appeals process for people who think that they have been treated unfairly or improperly by their county's social services agency. Such persons should contact their county agency or the Department's appeals section in St. Paul for the necessary appeals form.

The following are the names and phone numbers of Minnesota counties' mental health programs or community mental health centers and a list of the counties served by each. The centers and programs can be contacted directly by parents seeking evaluations and other services for their child.

To use this section (pages 38-44) of the booklet:

(1) Find the name of your own county acording to the alphabetical listing on pp. 38-41, and then look in the column to the right to find the name of the program or center serving your county.

(2) Next, find a description of that program or center in the material beginning on page 41. The centers/programs are also listed in alphabetical order.

Some of the counties may have made different arrangements for the provision of mental health services since they were originally contacted. However, by contacting the number listed with each, parents can learn of the arrangement currently in existence.

For those centers that returned a completed questionnaire to PACER, brief descriptions of the services they offer are included. (Because of their size, Hennepin and Ramsey Counties' programs will be covered in separate sections.)

Name of County	Name of Program Serving that County
Aitkin	NORTHLAND MENTAL HEALTH CENTER
Anoka	ANOKA COUNTY COMMUNITY HEALTH AND SOCIAL SERVICE
Becker	LAKELAND MENTAL HEALTH CENTER
Beltrami	UPPER MISSISSIPPI MENTAL HEALTH CENTER
Benton	CENTRAL MINNESOTA MENTAL HEALTH BOARD
Big Stone	BIG STONE COUNTY FAMILY SERVICE CENTER
Blue Earth	BLUE EARTH COUNTY FAMILY SERVICE CENTER
Brown	SIOUX TRAILS MENTAL HEALTH CENTER
Carlton	HUMAN DEVELOPMENT CENTER
Carver	CARVER COUNTY MENTAL HEALTH PROGRAM
Cass	UPPER MISSISSIPPI MENTAL HEALTH CENTER
Chippewa	WEST CENTRAL COMMUNITY SERVICES CENTER
Chisago	FIVE COUNTY HUMAN DEVELOPMENT PROGRAM
Clay	LAKELAND MENTAL HEALTH CENTER
Clearwater	UPPER MISSISSIPPI MENTAL HEALTH CENTER
Cook	COOK COUNTY SOCIAL AND HEALTH SERVICES DEPT.
Cottonwood	SOUTHWESTERN MENTAL HEALTH CENTER
Crow Wing	NORTHERN PINES MENTAL HEALTH CENTER
Dakota	DAKOTA COUNTY MENTAL HEALTH CENTER
Dodge	LUTHER YOUNGDAHL HUMAN RELATIONS CENTER
Douglas	LAKELAND MENTAL HEALTH CENTER
Faribault	FARIBAULT-MARTIN-WATONWAN HUMAN SERVICE BOARD
Fillmore	ZUMBRO VALLEY MENTAL HEALTH CENTER
Freeborn	FREEBORN COUNTY MENTAL HEALTH CENTER
Goodhue	ZUMBRO VALLEY MENTAL HEALTH CENTER
Grant	LAKELAND MENTAL HEALTH CENTER
Houston	HIAWATHA VALLEY MENTAL HEALTH CENTER

Hubbard	UPPER MISSISSIPPI MENTAL HEALTH CENTER
Isanti	FIVE COUNTY HUMAN DEVELOPMENT PROGRAM
Itasca	NORTHLAND MENTAL HEALTH CENTER
Jackson	JACKSON COUNTY WELFARE DEPARTMENT
Kanabec	FIVE COUNTY HUMAN DEVELOPMENT PROGRAM
Kandiyohi	WEST CENTRAL COMMUNITY SERVICES CENTER
Kittson	NORTHWESTERN MENTAL HEALTH CENTER
Koochiching	NORTHLAND MENTAL HEALTH CENTER
Lac qui Parle	WEST CENTRAL COMMUNITY SERVICES CENTER
Lake	HUMAN DEVELOPMENT CENTER
Lake of the Woods	UPPER MISSISSIPPI MENTAL HEALTH CENTER
Le Sueur	LE SUEUR COUNTY MENTAL HEALTH BOARD
Lincoln	WESTERN HUMAN DEVELOPMENT CENTER
Lyon	WESTERN HUMAN DEVELOPMENT CENTER
Mahnomen	NORTHWESTERN MENTAL HEALTH CENTER
Marshall	NORTHWESTERN MENTAL HEALTH CENTER
Martin	FARIBAULT-MARTIN-WATONWAN HUMAN SERVICE BOARD
McLeod	MC LEOD COUNTY SOCIAL SERVICE CENTER
Meeker	WEST CENTRAL COMMUNITY SERVICES CENTER, INC.
Mille Lacs	FIVE COUNTY HUMAN DEVELOPMENT PROGRAM, INC.
Morrison	NORTHERN PINES MENTAL HEALTH CENTER
Mower	MOWER COUNTY MENTAL HEALTH CENTER
Murray	WESTERN HUMAN DEVELOPMENT CENTER
Nicollet	SIOUX TRAILS MENTAL HEALTH CENTER
Nobles	SOUTHWESTERN MENTAL HEALTH CENTER
Norman	NORTHWESTERN MENTAL HEALTH CENTER
Olmstead	ZUMBRO VALLEY MENTAL HEALTH CENTER
Otter Tail	LAKELAND MENTAL HEALTH CENTER

Pennington	NORTHWESTERN MENTAL HEALTH CENTER
Pine	FIVE COUNTY HUMAN DEVELOPMENT PROGRAM
Pipestone	SOUTHWESTERN MENTAL HEALTH CENTER
Polk	NORTHWESTERN MENTAL HEALTH CENTER
Pope	LAKELAND MENTAL HEALTH CENTER
Red Lake	NORTHWESTERN MENTAL HEALTH CENTER
Redwood	WESTERN HUMAN DEVELOPMENT CENTER
Renville	WEST CENTRAL COMMUNITY SERVICES CENTER
Rice	RICE COUNTY MENTAL HEALTH CENTER
Rock	SOUTHWESTERN MENTAL HEALTH CENTER
Roseau	UPPER MISSISSIPPI MENTAL HEALTH CENTER
St. Louis	HUMAN DEVELOPMENT CENTER, (also, the RANGE MENTAL HEALTH CENTER serves the upper 2/3 of St. Louis County.)
Scott	SCOTT COUNTY HUMAN SERVICES BOARD
Sherburne	CENTRAL MINNESOTA MENTAL HEALTH BOARD
Sibley	SIOUX TRAILS MENTAL HEALTH CENTER
Stearns	CENTRAL MINNESOTA MENTAL HEALTH BOARD
Steele	LUTHER YOUNGDAHL HUMAN RELATIONS CENTER
Stevens	LAKELAND MENTAL HEALTH CENTER
Swift	WEST CENTRAL COMMUNITY SERVICES CENTER
Todd	NORTHERN PINES MENTAL HEALTH CENTER
Traverse	LAKELAND MENTAL HEALTH CENTER
Wabasha	HIAWATHA VALLEY MENTAL HEALTH CENTER
Wadena	NORTHERN PINES MENTAL HEALTH CENTER
Waseca	LUTHER YOUNGDAHL HUMAN RELATIONS CENTER
Washington	WASHINGTON COUNTY HUMAN SERVICES
Watonwan	FARIBAULT-MARTIN-WATONWAN HUMAN SERVICES BOARD
Wilkin	LAKELAND MENTAL HEALTH CENTER

Winona	HIAWATHA VALLEY MENTAL HEALTH CENTER
Wright	CENTRAL MINNESOTA MENTAL HEALTH BOARD
Yellow Medicine	WESTERN HUMAN DEVELOPMENT CENTER

ANOKA COUNTY COMMUNITY HEALTH AND SOCIAL SERVICE, Anoka County Courthouse, 325 E. Main St., Anoka, MN. 55303, (612) 421-4760, serves Anoka County (No other information received)

BIG STONE COUNTY FAMILY SERVICE CENTER, 340 N.W. 2nd St., Ortonville, MN. 56278, (612) 839-2555, serves Big Stone County (No other information received)

BLUE EARTH COUNTY HUMAN SERVICE BOARD, 410 South 5th St., Mankato, MN. 56001, (507) 625-9034, serves Blue Earth County (No other information received)

CARVER COUNTY MENTAL HEALTH PROGRAM, Chaska, MN. 55318, (612) 448-4900, serves Carver County. Outpatient services include: individual psychotherapy, family therapy, play therapy, psychological assessment and diagnosis. Sessions are usually held once per week but can be more frequent. The Center has no inpatient services and would send patients in need of hospitalization to the Golden Valley Health Center, Hutchinson Memorial Hospital, or North Memorial Hospital. The staff includes one licensed consulting psychologist, two psychologists who are completing doctoral work, three social workers with master's degrees, and one psychiatric nurse with a master's degree. The Center also has a part time psychiatrist.

CENTRAL MINNESOTA MENTAL HEALTH BOARD, 1321 13th St. N., St. Cloud, MN. 56301, (612) 252-5010, serves Stearns, Benton, Wright, and Sherburne Counties. Outpatient services include: individual, family, and group therapy. The length of therapy depends on the client's need and the availability of a therapist. There are no inpatient facilities or formal arrangements to provide hospitalization for patients. The staff includes licensed consulting psychologists, four of whom do some work with children and families; six psychiatric social workers; and one full time licensed psychologist.

COOK COUNTY SOCIAL AND HEALTH SERVICES DEPT., Courthouse, Grand Marais 55604, (218) 387-2282, serves Cook County

DAKOTA COUNTY MENTAL HEALTH CENTER, INC., 744 19th Ave. N., So. St. Paul, MN. 55075, (612) 455-9651, serves Dakota Co. Outpatient services include: individual, family and group counseling; diagnosis/ assessment/testing. Patients in need of hospitalization are directed to available facilities in the Twin Cities. The staff includes psychiatrists, psychologists, psychiatric social workers, and mental health educators. (See pp. 50, 51 for programs open to Dakota County residents through Human Resource Associates.)

FARIBAULT-MARTIN-WATONWAN HUMAN SERVICES BOARD, Martin County Courthouse, Fairmont, MN. 56031, (507) 238-4757, serves Faribault, Martin and Watonwan Counties. Outpatient services include group, individual, and family counseling. Patients in need of hospitalization are referred to a variety of hospitals in Mankato or the Twin Cities. The staff includes one PhD. psychologist; an education psychologist; two social workers with master's degrees; and three psychologists with master's degrees. There is no psychiatrist on staff at the present time.

FIVE COUNTY HUMAN DEVELOPMENT PROGRAM, INC., 205 Second St. S.,W., Braham, Mn. 55006, (612) 396-3333, serves Chisago, Isanti, Mille Lacs, Pine and Kanabec Counties. Outpatient services include: individual and family therapy (including play therapy); a formal family sexual abuse treatment program that includes group therapy and education for all family members; and, beginning this fall, therapy groups for children of alcoholic parents. Patients in need of hospitalization are referred to hospitals in the Twin Cities, St. Cloud and Duluth. The center's staff includes three psychologists, two social workers, one psychiatric nurse, one behavior analyst, and one psychiatrist. One of the psychologists has signing ability and can work with deaf youngsters.

FREEBORN COUNTY MENTAL HEALTH CENTER, Box 649, 231 E. Clark St., Albert Lea, Mn. 56007, (507) 373-6482, serves Freeborn County. Outpatient services include psychiatric and psychological evaluations and testing; individual, family, and group counseling. The length of sessions varies from one-half to two hours; group sessions are on a weekly basis. Evaluations last from one to three sessions; the length of the program varies according to need. The local hospital is used for clients in need of hospitalization. The staff includes two part time psychiatrists, one licensed consulting psychologist, one social worker with a master's degree, and one psychiatric social worker with a master's degree.

HIAWATHA VALLEY MENTAL HEALTH CENTER, Box 619, 50 W. 2nd St., Winona, MN. 55987, (507) 454-4341, serves Winona, Wabasha, and Houston Counties. Outpatient services include individual and group therapy and assessments. Patients in need of hospitalization are referred to hospitals in Winona, LaCrosse, Rochester or the Twin Cities. The staff includes licensed consulting psychologists, licensed psychologists, a consulting psychiatrist, a clinical social worker, and chemical dependency counselors.

HUMAN DEVELOPMENT CENTER, 1401 E. First St., Duluth, MN. 55805, (218) 728-4491, serves southern St. Louis County and all of Lake and Carlton Counties. Outpatient services include individual, family and group therapy; a day treatment program for elementary aged children; and special groups for children from families affected by violence. There are no inpatient arrangements. The staff includes two clinical psychologists, two mental health counselors, and two social workers. The Center also offers parent training.

JACKSON COUNTY WELFARE DEPARTMENT, Box 67, Jackson, MN. 56143 (507) 847-4000. Jackson County has recently begun to provide services through contracts with private psychologists. Patients in need of hospitalization would be referred to facilities in the surrounding area, Sioux Falls, and the Twin Cities.

LAKELAND MENTAL HEALTH CENTER, 126 E. Alcott Ave., Fergus Falls, MN. 56537, (218) 736-6987, serves Otter Tail, Becker, Pope, Stevens, Traverse, Grant, Douglas, Wilkin, and Clay Counties. (No other information received.)

LE SUEUR COUNTY MENTAL HEALTH BOARD, Courthouse, LeCenter, MN. 56057, (612) 357-2251, serves LeSueur County. Outpatient services include, mainly, family therapy and, rarely, individual therapy. The staff includes a full-time psychologist with a master's degree, a part-time social worker with a master's degree, a part-time licensed consulting psychologist, and a part-time licensed psychologist. People in need of hospitalization are referred to the University of Minnesota hospital or to others elsewhere in the state.

LUTHER YOUNGDAHL HUMAN RELATIONS CENTER, 215 South Oak St., Owatonna, MN. 55060, (507) 451-2630, serves Steele, Dodge, and Waseca Counties. Outpatient services include assessment, diagnosis, and individual therapy; play therapy; family therapy; sexual abuse group therapy. Sessions with children usually

last for ten to twelve visits. There are no inpatient arrangements. The staff includes four psychologists, two psychiatrists, and two social workers.

MC LEOD COUNTY SOCIAL SERVICE CENTER, County Office Building, P.O. Box 207, Glencoe, MN. 56336, (612) 864-5551. At the time this booklet was being prepared, McLeod County's Social Service Department was accepting proposals from various agencies to provide services to county residents in need of mental health care. The number above, that of the Social Service Department, is the one which should be contacted to learn of arrangements that have been made for service provision.

MOWER COUNTY MENTAL HEALTH CENTER, 903 First Drive Northwest, Austin, MN. 55912, (507) 433-7389, serves Mower County. Outpatient services include: evaluation (usually one session for one to two hours); individual therapy (averages six to eight sessions, one hour each); group therapy (one session weekly for an unlimited number of sessions); family therapy (averages six-eight sessions, one or two hours each); aid to victims of assault and crime (patients would be seen several times during the month following the crisis). The staff includes a licensed consulting psychologist; a staff psychiatrist; a psychiatric nurse with a master's degree; a psychiatric social worker with a master's degree; and a victims' crisis center coordinator and aide.

NORTHERN PINES MENTAL HEALTH CENTER, First National Bank Building, Little Falls, MN. 56345, (612) 632-6647, serves Morrison, Todd, Cass, Wadena, and Crow Wing Counties. Inpatient services include individual counseling or psychotherapy. The staff includes a licensed consulting psychologist; a psychiatrist; and seven therapists, four of whom are listed as having master's degrees.

NORTHLAND MENTAL HEALTH CENTER, 215 Southeast Second Avenue, Grand Rapids, MN. 55744, (218) 326-1274, serves Aitkins, Itasca, and Koochiching Counties. Outpatient services include individual and family diagnostic evaluations; individual and family therapy; group therapy for adolescent victims of incest/sexual assault. The duration of services depends upon the patient's needs. Inpatient evaluations of adolescents and families are available through the Center and Itasca Memorial Hospital Psychiatric Service. The staff at the Center includes one licensed consulting psychologist; one school psychologist; one social worker; one psychologist with a PhD.; one psychologist with a master's degree, and two staff psychiatrists.

NORTHWESTERN MENTAL HEALTH CENTER, College Avenue, Crookston, MN. 56716, (218) 281-3940, serves Polk, Norman, Mahnomen, Red Lake, Pennington, Marshall and Kittson Counties. Outpatient services, according to a brochure distributed by the center, include "diagnostic and treatment" services. The staff includes a psychiatrist, clinical psychologists, psychiatric social workers, and "mental health personnel."

RANGE MENTAL HEALTH CENTER, 624 13th St. S., Virginia, MN. 55792, (218) 749-2881, serves northern St. Louis County. Inpatient services include: individual, group and family therapy; assessment and evaluation; 24-hour emergency service. Hospitals in Virginia and Hibbing are used for short term assessments only. The staff includes two licensed consulting psychologists; one children's worker with a bachelor's degree; two family therapists with master's degrees in social work.

RICE COUNTY MENTAL HEALTH CENTER, Rice County Social Services, 128 N.W. 3rd St., Faribault, MN. 55021, (507) 334-2281, serves Rice County. Outpatient services include individual therapy, some group therapy, family therapy, and assessments. Patients in need of hospitalization would be referred to the Golden Valley Health Center or to other hospitals in the Twin Cities. The staff includes a fulltime social worker with a

master's degree, a full-time psychologist with a master's degree, a part-time psychologist (PhD.), and a part-time psychiatrist.

SCOTT COUNTY HUMAN SERVICES BOARD, 699 County Rd. 83, Shakopee, MN. 55379, (612) 455-7550, serves Scott County. (No other information received.)

SIOUX TRAILS MENTAL HEALTH CENTER, 1407 S. State St., New Ulm, MN. 56073, (507), 354-3181, serves Brown, Nicollet, and Sibley Counties. Outpatient services include individual and family therapy; the length of therapy and its frequency depend upon the client's needs. Patients in need of hospitalization are sent to hospitals in New Ulm and Mankato. The staff includes one psychiatrist; three licensed consulting psychologists; two licensed psychologists; and two clinical social workers.

SOUTHWESTERN MENTAL HEALTH CENTER, Box D, 2 Round Wind Road, Luverne, MN. 56156, (507) 283-2396, serves Rock, Nobles, Pipestone, and Cottonwood Counties. Outpatient services include: evaluations; counseling for children, adolescents, and families using a multi-disciplinary team approach. Typically, clients are seen for eight to twelve sessions of one hour per week. The Center operates its own halfway house for emotionally disturbed adolescents. Patients in need of hospitalization are sent to Sioux Falls; however, there will soon be inpatient facilities opening in Worthington. The staff includes two doctoral level psychologists, two master level social workers, and one pastoral counselor.

UPPER MISSISSIPPI MENTAL HEALTH CENTER, 722 15th St., Box 646, Bemidji, MN. 56601, (218) 751-3280, serves Roseau, Lake of the Woods, Clearwater, Beltrami, Hubbard and Cass Counties. (No other information received.)

WASHINGTON COUNTY HUMAN SERVICES, 7066 Stillwater Boulevard North, Oakdale, MN. 55119, (612) 738-0080, serves Washington County. (No other information received.)

WEST CENTRAL COMMUNITY SERVICES CENTER, 1125 S.E. 6th St., P.O. Box 787, Willmar, MN. 56201, (612) 235-4613, serves Lac qui Parle, Chippewa, Swift, Renville, Kandiyohi, and Meeker Counties. Outpatient services include individual, family, and group therapy; play therapy; behavior modification; hypnotherapy; medication management; 24-hour crisis intervention services; and day treatment programs for adolescents. Short-term, intensive hospital care is available through the mental health unit in Hutchinson Community Hospital. The center's staff includes psychiatrists; psychologists (PhD., EdD., and master's levels); social workers; mental health counselors (master's and bachelor's degree levels); occupational therapists; and a pastoral counselor.

WESTERN HUMAN DEVELOPMENT CENTER, 1106 E. College Dr., Box 450, Marshall, MN. 56258, (507) 532-3236, serves Lincoln, Lyon, Murray, Redwood, and Yellow Medicine Counties. Outpatient services include parent education classes (five, once-a-week sessions); individual therapy (one session per week for six to ten weeks); and family therapy (one session per week for six to ten weeks). Patients in need of hospitalization would be referred to Willmar State Hospital or to private hospitals in Sioux Falls or the Twin Cities. The staff includes three psychologists and three social workers.

ZUMBRO VALLEY MENTAL HEALTH CENTER, Box 1113, Rochester, MN. 55901, (507) 288-1873, serves Olmsted, Fillmore, and Goodhue Counties. Outpatient services include a variety of individual, group and family therapy sessions. The number of sessions would vary, but they would usually be held weekly. There are no arrangements for inpatient care. The staff includes a psychiatrist, psychiatric nurse, three psychologists, and one social worker.

Hennepin County services

In Hennepin County, most county-connected services are offered to emotionally disturbed children and adolescents through the Mental Health Division. Those Division programs that involve youngsters are the Hennepin County Mental Health Center, the Pilot City Mental Health Center, and many programs that the county doesn't operate itself but contracts with to provide services. Services through the Mental Health Division are provided on a sliding scale fee basis.

THE HENNEPIN COUNTY MENTAL HEALTH CENTER (HCMHC) has two locations, its main offices in downtown Minneapolis at 619 S. 5th St., (347-5770) and a suburban branch in Crystal at 5702 W. Broadway, (533-2600). All services through HCMHC are on an outpatient basis.

HCMHC is staffed by three full-time psychologists and two full-time social workers; at the time of this booklet's preparation, there was no psychiatrist on the staff so children in need of medication would be referred to a program run at the Hennepin County Medical Center (described later) or to a private doctor.

The types of therapy programs used at the HCMHC include play therapy, behavior modification therapy, psychotherapy, family therapy, and group or peer therapy.

The HCMHC does not have inpatient facilities for patients who need hospitalization. Parents whose children undergo a nighttime emergency are encouraged to call the county's Crisis Intervention Unit (described later in this section); that unit would let HCMHC know the next day if one of its patients had entered a hospital.

HCMHC, in addition to providing outpatient therapy, also performs psychological evaluations of youngsters. Their recommendation, based on the evaluation, could be to treat the child at HCMHC, to place him or her in a school special education program for emotionally disturbed youngsters, or possibly to place him in a residential treatment center for 24-hour care and help. Or the results of the evaluation could indicate that no treatment program is needed.

Parents should feel free to contact either number above to begin the intake process. Depending on their incomes, parents might be charged nothing for services or amounts ranging up to a maximum of $46 per hour.

THE PILOT CITY MENTAL HEALTH CENTER, 1349 Penn Ave. N., Mpls., 348-4625, serves all Hennepin County residents but primarily those who live in the Near North and Camden neighborhoods of Minneapolis and adjacent geographical areas. Payments for services are also on a sliding scale basis and dependent on family income. The Center provides assessments, diagnoses, and treatment services on an outpatient basis and offers individual, group and family therapy; medication management; and home visits. Parents can contact the Center directly at the number above.

The Center works closely with other community resources serving children, including schools, child welfare, and child protection and court services. The staff includes five clinical psychologists and two psychiatric social workers.

Contracted services

Hennepin County does not itself operate the following programs. However, it has made contract arrangements with the facilities to provide services, at reduced rates when appropriate, to emotionally disturbed children and adolescents.

Parents may approach all of the following facilities directly to seek services; the county does not need to be involved or to approve the services being offered to an individual youngster. (The programs under discussion here are all non-residential; in contrast, county participation in a decision to place a child out of his/her home is required before the county will assist with the costs of that kind of program.)

THE CHILDREN'S HEALTH CENTER PRESCHOOL DAY TREATMENT PROGRAM, 2011 Chicago Ave. S., Mpls., 874-6135. This program is also known as the Therapeutic Nursery and is described fully in the section on hospital-based programs.

COMMUNITY-UNIVERSITY HEALTH CARE CENTER - MENTAL HEALTH UNIT, 2016 16th Ave. S., Mpls., 376-4774. Service priority at this Center is given to a low-income, minority population (including Blacks, Native Americans, and Indochinese). Translators are available for French, Spanish, Chippewa, Sioux, Laotian, Hmong, and Thai patients. The Center offers individual, family and group outpatient therapy; screening and assessment services; referrals; crisis counseling; and support groups. The program works closely with schools and other agencies that serve minorities.

FAIRVIEW DEACONESS FAMILY HEALTH PROGRAM, 1305 E. 24th St., Mpls., 721-9471. The orientation of this program is to try to keep families together in troubled circumstances. It offers crisis counseling, phone counseling and referrals, assessments, and short-term outpatient treatment. The client population is primarily low income, Black and Native American families from south-central Minneapolis. The program specializes in dealing with problems and concerns of the Native American community.

FAMILY FOCUS, 4901 W. 112th St., Bloomington, MN. 55437, 884-8831. (This program is described separately in the last section of this booklet, titled "When Agencies Work Together.")

FAMILY NETWORKS, INC., 720 E. 26th St., Mpls., 872-2345. This is a day treatment program that provides intensive (up to seven hours per day) mental health services to 20 emotionally disturbed adolescents, ages 14 to 18. Clients' immediate and extended families also are involved in treatment. The agency utilizes individual and group therapy, job readiness training, vocational and recreational activities, and family therapy. Treatment services generally last from six to nine months.

THE HOUSE, 3968 W. Broadway Ave., Mpls., 533-5213. This is a family counseling center and provides individual, group and family outpatient treatment, crisis counseling, and educational workshops, primarily to residents of the northwestern Hennepin County suburbs. The agency provides group services for children, but the emphasis is on dealing with family stress rather than on treating a child individually. The agency offers walk-in or unscheduled counseling three times a week.

ST. JOSEPH'S DAY TREATMENT PROGRAM, 1120 E. 47th St., Mpls., 827-6241. The Minneapolis public schools and St. Joseph's together operate a day treatment program for elementary school youngsters (ages five through twelve) with a capacity for 24 students. The primary entrance criteria is an emotional disturbance.

Intake is done on a year round basis. In addition to the child's specialized school experience, he or she receives individual, group, and family therapy; therapy programs are provided by social workers with master's degrees. Occupational, music, and recreational therapy are also part of the program, and psychiatric and psychological consultation with outside professionals is requested by St. Joseph's whenever needed.

SOUTH HENNEPIN FAMILY AND CHILDREN'S SERVICES, 9301 Bryant Ave. S., Bloomington, 340-7448; an Outreach Office at 33 Fourth St. N.W., Osseo, 424-6353. This program provides evaluation and assessment; individual,

family and group treatment; and family life education services -- primarily to residents of the south Hennepin County area. The emphasis is on assessing and treating problems in a family context.

STOREFRONT/YOUTH ACTION, INC. - DELTA PLACE, 1001 State Highway 7, Hopkins, 938-7040. This is a new day treatment program for adolescents, ages 13-17. They would continue to live at home, but come to the program for individual, group and family therapy, for pre-vocational services, and for training in independent living skills. The program works with the West Metro Education Center to integrate the mental health services with the clients' special education programs. Delta Place can serve twenty adolescents at a time.

WALK IN COUNSELING CENTER, 2421 Chicago Ave. S., 870-0565. The Center provides crisis or short-term, unscheduled counseling to adolescents who walk in off the street; their address is 2421 Chicago Ave., S., Minneapolis. Treatment is directed at those who've become alienated from other services or who are unaware of other facilities or programs. The agency will refer persons to other service providers when needed. Services are free of charge and are provided by volunteer professionals. The Center provides services week-day evenings and also has afternoon hours three days a week.

WASHBURN CHILD GUIDANCE CENTER, 2430 Nicollet Ave. S., Mpls., 871-1454. Washburn provides diagnostic and treatment services to children and families. Children to age 18 can be served, but those over age 14 will be seen for diagnosis, evaluation, and referral only. Outpatient treatment services include individual and family therapy; children's therapy groups; psychological and psychoeducational testing; and community education. Washburn also has preschool and summer day treatment programs for disturbed children.

WEST HENNEPIN COMMUNITY MENTAL HEALTH CENTER, 14500 Minnetonka Blvd., Minnetonka, 935-8411. This center serves primarily Hennepin County's western suburbs. It provides individual, family and group outpatient treatment, crisis counseling, and assessments. It works closely with the schools for assessments and referrals.

YES (Youth Emergency Services) and NEON (Nighttime Emergency Outreach Network), 608 20th Ave. S., Mpls., 339-0895. YES is a telephone counseling service that operates around the clock seven days a week. It offers brief counseling, crisis intervention, information, and referals to anyone in need of assistance. NEON provides on-site or by-phone crisis intervention between 8 p.m. and 8 a.m. seven days a week. After providing brief counseling and intervention services, they attempt to link people with community resources that can be of help.

Programs outside the Mental Health Division

(The following services are operated by Hennepin County but not through its Mental Health Division.)

RESIDENTIAL CARE - Parents who are seeking a residential placement for their child should first enlist the services of a county social worker by contacting Hennepin County's Family Services department at 348-2324. The social worker would work with parents and, if out-of-home placement seems the right course, direct them to the appropriate coordinator with the Community Service Department's Child Placement Unit. Placement in a residential treatment center, (described in a later section of this booklet), a group home, or in foster care might be options.

THE CHILD PSYCHIATRY UNIT OF HENNEPIN COUNTY MEDICAL CENTER, 347-2617 or 347-2492. This program, operated by the county's Medical Center, does not have a sliding scale arrangement for payment of fees. Its services could be eligible for insurance coverage or Medical Assistance.

The staff of the unit includes two child psychiatrists, four psychologists, and two interns. The unit also provides access to speech and language clinicians, pediatricians, and pediatric neurologists. A parent can approach the unit by calling the number above. As soon as a staff member is free, he or she would call the parent to set up an appointment for a first visit.

The admissions process would include two visits with the family during one of which a complete case and family history would be done. An evaluation of the child would include an assessment of his intellectual, academic, and emotional status.

The family would be involved in decisions about the child or adolescent's treatment. Families would probably also participate in the therapy, either working by themselve with a counselor or working as part of a group with their child.

Types of therapy offered include behavior management, psychotherapy, family therapy, some group therapy, and supportive therapy to help the family cope with the child's difficulties.

Medications are not commonly used within this unit.

The Child Psychiatry Unit also has available a special team that combines pediatricians, psychologists, speech and language teachers, and teachers experienced in working with learning disabilities. The team workr with children in grades K-3 whose major problem is a learning difficulties but who have an associated emotional disorder.

THE CRISIS INTERVENTION CENTER, 347-3161. This is a round-the-clock service that charges no fees. It's staffed with psychiatrists, a clinical psychologist, psychiatric social workers, nurses, and mental health workers. Parents who are facing an emergency situation with their child can call the Center. A staff member would establish if there actually is a true crisis. If so, the family might be asked to bring the youngster to the Center.

The staff on duty would screen the child. Their decision might be to hospitalize the youth, to arrange for him or her to see a psychiatrist or other professional within the near future, or perhaps to simply separate the child and parents for a short while.

Persons unsure of whether or not a problem is a crisis situation are welcome to call the Intervention Center and consult over the phone.

The unit's staff is trained in connecting people with problems to the services they need.

Ramsey County services

Ramsey County's programs for emotionally disturbed children and adolescents are run through the Mental Health Division of its Community Human Services Department and through a Purchase of Services contract with the Wilder Child Guidance Center. The County's Mental Health Center is located at 529 Jackson St. in St. Paul, 298-4737.

The Center has a sliding scale fee arrangement for its services. Parents with very limited incomes might also be advised to see if they could qualify for an income assistance program - in addition to receiving very low cost mental health care for their child. Other parents who are working but unable to afford medical costs might have their bill waived entirely or pay only a token amount, according to the administrator of the Mental Health Division.

Parents can approach the Center directly by calling the number above. After doing so, they would be asked to come to the Center in person for the intake process which takes place at 9:00 a.m. and at 1:00 p.m. daily, Monday through Friday.

Staff meetings where a child's case is discussed and a therapist assigned are held on Tuesdays and Thursdays. Typically, an assignment would be made within a week from the time the parents first came to the Center.

Persons calling the intake number at night due to an emergency would be told to contact St. Paul Ramsey Hospital.

Ramsey County's Mental Health Center has no separate child's unit within the clinic. Its staff includes one part time child psychiatrist, psychiatric nurses, social workers, and psychologists. Those with special skills in working with youngsters will be assigned when possible to the young patients. The clinic does provide medications, but only on a limited basis due to the psychiatrist's part time status.

The typical treatment program is divided between individual therapy for the youngster and therapy that works with the child and his/her family together as a unit. Sessions might be held once a week or more often during a crisis situation.

PROVISION OF RESIDENTIAL CARE - Ramsey County's Community Human Services Department provides for children who need residential placement through contracts made with several Residential Treatment Centers (described in a separate section). To place a child in such a Center, parents would need to contact the Department and gain its approval for the youngster's placement. The County pays the Centers directly for the youth's care and treatment; it then collects whatever reimbursement it can obtain from the parents and their insurance company.

Like Hennepin County, Ramsey County also has signed contracts with various facilities that it doesn't operate itself. These facilities then provide services to residents with emotional disorders on a reduced fee basis. Families are asked to pay whatever they can for their service, and their insurance policies, if any, can also be used to help cover costs. The remainder of the costs would be born by the county and/or the facility itself.

THE WILDER FOUNDATION, 642-4000. The Wilder Foundation's Division of Services to Children is a major source of help for emotionally disturbed youngsters who are residents of Dakota, Ramsey, Anoka and Washington Counties. It provides both out-patient and residential services.

The Division's Child Guidance Clinic consists of the main clinic at 919 Lafond Ave., St. Paul, plus four

branches: the Dakota Branch at 13760 Nicollet Ave. in Burnsville, the North Suburban Branch at 248 White Bear Ave. in Maplewood, the Northwest Branch at 5100 Edgewood Dr. in Moundsview, and the Old Hudson Road Branch at 1867 Old Hudson Road in St. Paul. The clinics offer psychological and psychiatric evaluations; mutual support groups; parent training, and varying combinations of individual, family, group, or medical treatment.

Parents from the four counties served may approach the Clinic directly by calling the number above. Cost of the services would be covered by: (1) insurance of Medical Assistance if clients are eligible, (2) private payment - Wilder does have a sliding scale fee arrangement, (3) partial reimbursement from Ramsey County, and (4) the Wilder Foundation.

Services to Children also operates a program called the Eisenmenger Learning Center (919 Lafond Ave., St. Paul) in conjunction with the St. Paul school district. The Learning Center is for children, ages five through seventeen, who have learning and behavior or emotional problems. The program has three components: (1) an out-patient program, (2) a classroom program for elementary age children, and (3) a special program for learning disabled adolescents. Placement in the classroom program would be through a child's school. Parents may apply directly for the out-patient program.

Though students from the city of St.Paul are given preference in placement, the program is open to all students from Wilder's four-county service area. Services through Eisenmenger are basically free of charge though there might be a fee for certain components of the program such as a vision assessment.

The Center offers assessments of the child's educational ability and of his vision and speech/language skills; counseling; remedial education; occupational therapy; an academic program; and treatment of his emotional disability. The Learning Center can be contacted at 642-4030.

HUMAN RESOURCE ASSOCIATES, 439 St. Clair Ave., St. Paul, 228-1148. One of Human Resource Associates' main programs is a day treatment program for adolescents, ages 12-17 who are Ramsey County Residents. Parents who will need assistance with payment would need to have a a referral for their youngster from the Placement Review Team of Ramsey County's Human Services Department. According to the program's administrative director, this program is not eligible for insurance reimbursement so costs would be prohibitive for most parents except with county help.

The program, which has a capacity for 16-20 youngsters, runs from three to six p.m. during the school year; youngsters would continue to attend their regular school earlier in the day. The program continues over the summertime but on a different schedule.

The staff includes one part time psychiatrist, two fulltime social workers with master's degrees, and a psychologist with a bachelor's degree.

A child's family or foster parents are required to take part in family counseling and parent education training. Group and individual therapy are done with the adolescent on the program's site. He or she would also be taken on field trips. The program's Saturday component is especially oriented toward participation in community affairs.

A diagnosis of the child as emotionally disturbed must have been made before he or she enters the day treatment program. During the program, this diagnosis would continue to be refined.

Human Resource Associates runs a similar program for adolescents who are residents of Dakota County; parents there would need to contact Dakota County Human Services for a referral.

Finally, Dakota County residents are eligible for free assessments of their child done through Human Resource Associates; the service is called the Youth Assistance Program and can be contacted at 437-3976.

Hospital-based programs

The following are those hospital based programs in the Twin Cities that came to PACER'S attention; we regret that budget restrictions prevented a statewide survey or if any metropolitan area programs have been overlooked.

Hospital-based programs are usually thought of as being designed for the most seriously disturbed youngsters. However, all parents will want to be aware of those programs described in the next pages for two reasons:

1. Certain hospitals are now offering services on an outpatient basis, among them, comprehensive diagnostic clinics and day-treatment programs. These could well be a choice for children whose problems don't require actual hospitalization.

2. In the event that a youngster's difficulties mount and he or she enters a crisis stage, parents will want to know where to turn quickly.

Minneapolis area

ABBOTT NORTHWESTERN - CHILDREN'S INPATIENT UNIT

This is a 20-bed, locked unit that accepts both boys and girls from age two up to ninth graders (14 or 15). The average length of stay may be as short as the time required to assess or evaluate the patient or as long as up to three months for a treatment program. Each patient's stay is determined by his parents and doctor, and his/her care is tailored to his/her individual needs.

The unit treats children with conduct or behavior disorders and those who are hyperactive or depressed. Its focus is on the inclusion and involvement of the family as much as possible in the child's individual treatment plan.

Referral to the unit can be made through a family doctor. However, parents can also approach the unit directly by calling 874-4672 (M-F, daytime) or 874-4047 (evenings and week-ends). Those doing so would then be given a list of doctors with admitting privileges to contact. The admitting psychiatrist would continue to see the child regularly. A psychiatric work up or evaluation would be done when the child enters the unit, and a consulting psychologist could also be called in for testing.

Besides the admitting psychiatrist, the other staff members include registered nurses and mental health counselors plus occupational, recreactional, therapeutic specialists, and group therapists. On a one-to-one basis, each child will work with a therapist each day - in addition to his visits with his psychiatrist. Children will also take part in a variety of groups such as cooking, exercise, and social. Because the families of disturbed children are so often in crisis themselves, according to the charge nurse on the unit, family therapy is also encouraged. There is also a support group for parents of children in the unit as well as a group that teaches parenting skills and how to set limits.

ABBOTT NORTHWESTERN - ADOLESCENT INPATIENT UNIT

The adolescent unit, also with a capacity of 20 beds, will take boys and girls from grades 10 and up, or who're aged 15-18. This is a locked unit.

The unit operates on a code system where the patients try to meet goals in order to earn higher codes and greater ward privileges.

The staff includes psychiatric nurses; occupational, recreational, and group therapists; a chaplain; and mental health counselors.

Parents could receive a referral from

their family doctor for the child; they can also approach the unit directly by calling 874-4048 . They would then be given a list of admitting physicians who are child/adolescent psychiatrists.

Each adolescent would be seen about three times each week by his/her admitting psychiatrist. S/he'd take part in the same types of groups as do the younger children in the children's inpatient unit, and s/he'd also work individually with a therapist each day.

Family therapy now is initiated at the discretion of the individual physician. The unit's head nurse said that one of the unit's goals is to involve families more in the program. There is a support group for parents of patients in the ward.

Though the unit is locked, the clients are given opportunity for supervised, off-unit activities such as going to the gym, exercise room, and swimming pool.

An adolescent crisis unit, designed for short term stays, is expected to open at Abbot in the near future.

Both of Abbott's programs could be eligible for insurance reimbursement and Medical Assistance. However, the hospital does not have Hill Burton funds available.

NORTH MEMORIAL HOSPITAL - CHILD GUIDANCE CLINIC (520-5700)

This is an outpatient program for children, ages two through eighteen. It provides diagnosis and evaluation services and then treatment for those youngsters whose admission into the clinic is recommended.

The staff consists of three psychologists, a pediatrician, one social worker, two speech/language clinicians, and an occupational therapist. Children with learning problems, behavior disorders, and emotional disorders are eligible for the program.

Therapy sessions might be held from twice weekly to only once every two weeks, depending on the youngster's or family's needs. The program provides group therapy, family therapy, and individual therapy.

The program's director emphasizes the close working relationship of the clinic's program with the child's schools. The clinic serves a dual function: (1) to advocate for the child and (2) to cooperate with his or her school, letting personnel there know of the clinic's findings and how that information may facilitate the child's growth and development in school.

Insurance plans genrally cover payment of the clinic's program; also, there is a provision for some fee negotiation.

NORTH MEMORIAL HOSPITAL - CRISIS UNIT (520-5385)

This is a unit for both adolescents and adults; the youngest age accepted is twelve. Both boys and girls can be admitted.

The maximum stay for an adolescent is ten days; the unit is not a treatment program but does evaluations and deals with the compelling needs of the crisis. It provides eight spaces for adolescents.

A child in a crisis situation could be brought to the hospital's emergency room where an admitting doctor would be found. That would be the staff psychiatrist on call, and he or she would continue to have responsibility for the youth in the unit.

The unit's evaluation team consists of nurses, social workers, a psychologist, an occupational therapist, a physician, and a recreational therapist.

North Memorial does not have Hill Burton funds available. Its services could be eligible for insurance reimbursement and Medical Assistance.

GOLDEN VALLEY HEALTH CENTER - INPATIENT UNIT - VALLEY YOUTH CENTER (588-2771, extension 5050)

Golden Valley's program will take children ages two through fourteen, or possibly fifteen, who have been referred by the staff's child psychiatrists (their names may be obtained by calling the Health Center). The unit, which is locked, has 22 beds.

A child's maximum stay in the unit is 90 days, and the program is designed for evaluation and a short term treatment program.

The unit is staffed by "clinical associates" (who have bachelor's degrees in a human service related field and two years experience in a medical facility), registered nurses, activity leaders, occupational therapists, and musical therapists.

Each child is assigned to a primary staff person who is responsible for coordinating his or her care. Also, each patient sees his or her own psychiatrist three times weekly.

The unit takes children who are psychotic (separated from reality), have behavior disorders, or suffer from attention deficits (often called hyperactivity in the past).

Patients take part in musical, recreational and occupational therapy; their primary treatment is shaped around "milieu" therapy (where everything and everyone they encounter is considered part of their treatment and shaped to fit into their treatment's goals and purposes).

Golden Valley conducts a STEP program for parents; it stands for "systematic training for effective parenting" and encourages parents to spend time on the unit, observing the staff work with their children. STEP is based on the theory that all behavior has a purpose; the purpose should be recognized and new methods learned to deal with the behavior.

There is no sliding fee scale at the Health Center. Medical Assistance and insurance are accepted. The Center does not have Hill Burton funds available.

FAIRVIEW DOWNTOWN - ADOLESCENT CRISIS UNIT

This unit is geared toward adolescents (ages 13-17) who are in crisis situations; therefore, their stay can last no longer than three weeks. The patients accepted here might be considering suicide, having an acute psychotic episode (separation from reality), or be of danger to others.

Referrals might come from doctors, social workers or the courts. Parents calling the unit directly at 371-6435 would be given a list of child/adolesent psychiatrists who could be assigned to their child and responsible for his or her care on the unit.

Screening and actual admission to the unit is done primarily over the telephone and is handled by the unit's staff.

Besides simply keeping the adolescent in safety throughout the crisis, the unit's main purpose is to evaluate him or her and to make recommendations for long term therapy.

During his or her stay on the locked unit, the adolescent will see the admitting psychiatrist approximately three times each week and, to a small degree, begin a treatment program. Also on the staff are registered nurses, psychiatric technicians, occupational and recreational therapists, and group leaders. There are approximately two patients to each staff member.

FAIRVIEW DOWNTOWN - ADOLESCENT TREATMENT PROGRAM

This is a locked unit for adolescents, ages 12-17, of either sex. A stay here averages around six weeks.

Patients include those with serious behavior disorders, schizophrenia, depression, or severe family dysfunctions. The unit has a capacity of 19 beds, and another one is being added.

The staff includes registered nurses and psychiatric technicians; patients must be admitted by a psychiatrist, and he or she would then see the admitting doctor about three times each week. The psychiatrist must have admitting privileges to Fairview. Parents can call the unit at 371-6539 to learn the names of the doctors who would need to be contacted prior to any admission.

A complete psychiatric work up is done as part of the intake process. While in the unit, the patient would participate in behavioral therapy, family therapy, group therapy, and educational seminars on such topics as human sexuality and drugs and survival skills. A family worker on the staff would see each patient's family about once a week.

FAIRVIEW DOWNTOWN - ADOLESCENT LONG TERM PROGRAM

This is a unit for patients who have even more complicated problems than those in the Adolescent Treatment Program just described. According to the unit's head nurse, patients admitted to this program have had serious difficulty in functioning - for one reason or another - probably since they were very young.

The unit has 20 beds and takes both boys and girls, ages 12-17. The program lasts for three to six months or longer.

Patients would not be admitted to this unit, which is locked, unless they had run away from or failed in another treatment program.

All referrals must go through Fairview's admitting psychiatrists; a list can be gained by calling the unit at 371-6549 . Further, admissions to this unit have to be approved by the Medical Director of Adolescent Psychiatry.

Since the patients here have been in other programs, an independent psychiatric work up is not done unless their previous records are incomplete for some reason.

The patient to staff ratio is three to one; the staff includes registered nurses, psychiatric technicians, group therapists, a family worker, and an ocupational and a recreational therapist. The unit combines highly individualized treatment plans and a very structured environment (everyone and everything with whom the patient comes in contact is regarded as part of the treatment plan; the goals toward which his/her behavior is shaped are known to all staff, and everything s/he does or takes part is designed to help the patient progress. This is known as milieu therapy.

This unit offers a support group for parents in addition to family therapy.

FAIRVIEW DOWNTOWN - DAY HOSPITAL PROGRAM

In this unit, which takes children ages 12-17, clients would continue living at home but attend the hospital's program duing the daytime. They'd also receive their academic instruction at the hospital.

The program usually has around 16 patients, but its head nurse said it has an "open ended" capacity, i.e., there's no ceiling on admissions.

Parents can approach the program directly by calling 371-6684; screening would be done over the phone, and the program's case manager said the staff can usually decide in that manner if a child should be admitted. They'd also provide the parents with the names of admitting doctors, one of whom would have to be contacted and would continue to see the child after admission. However, the youngster could be admitted before being seen by the doctor.

Children admitted to the program would have such problems as depression,

withdrawal, a separation from reality, a phobia about attending school, behavior disorders, or severe eating difficulties. A child who is potentially suicidal or of danger to others would be referred to the crisis unit.

The unit has a family worker who meets with the family, a group that could include the child himself, parents, siblings, and grandparents.

Complete psychiatric assessments are made when the child enters the unit; his treatment plan will include group therapy, occupational therapy, one-to-one therapy and recreational therapy. Speech and language evaluation and treatment services are available on an individual basis.

The length of time spent in the program varies greatly from one patient to the next.

All Fairview programs described above may be eligible for insurance reimbursement and for Medical Assistance. The hospital does not have Hill Burton funds available.

MINNEAPOLIS CHILDREN'S HEALTH CENTER - THE OUTPATIENT MENTAL HEALTH CLINIC

The clinic offers comprehensive diagnostic and treatment services to children ranging from preschool age through adolescence. Social, psychological, and psychiatric evaluations are done by specialists in child psychiatry, child psychology, and clinical social work. On an outpatient basis, those accepted into the clinic could receive long- or short-term individual psychotherapy, family therapy, group therapy, parent therapy, play therapy, and crisis intervention services.

Parents can call the clinic directly to arrange an appointment for their child; the number is 874-6138, and calls can be taken from 8 a.m. to 5 p.m. Mondays through Fridays and from 5 to 8 p.m. on Wednesday evenings. Fees at the clinic can be paid for by the family, by insurance, or through Medicaid; flexible payment schedules may also be possible.

MINNEAPOLIS CHILDREN'S HEALTH CENTER - THE THERAPEUTIC NURSERY

The nursery is a treatment program for emotionally disturbed preschool children (ages 22 months to five years). Therapy is provided through play, social activities, art and music, all under the guidance of professionals who help the children work through their difficulties as problems surface during the activities.

The kinds of children served at the nursery include: those with behavior problems whose difficulties prevent adjustment to nursery school or family routines; children whose ability to relate to others is impaired; youngsters suffering from a lasting disturbance linked to some difficult early life event (such as a separation from parents or a hospitalization); children undergoing a current trauma; and children with evident emotional disturbances who need immediate attention to avoid residential or foster care placement.

Parents may also receive training in effective parenting techniques through the program even though their child is not receiving services.

Parents can call the Nursery directly at 874-6135. An intake worker would talk to them over the phone and then ask that the child be brought in for an evaluation interview (the process would not be as complete as that done at the Clinic itself.)

The Nursery might recommend that the child be admitted, that he might be better served through a program elsewhere, or that the parents should be worked with alone.

The Nursery is staffed by a social

worker, a psychologist, and two child therapists. There is also access to specialists on the Clinic's staff.

Fee arrangements at the Nursery are the same as those for the Clinic's services except that the Nursery also has a sliding scale fee arrangement.

Children's Hospital does not have Hill Burton funds available.

MERCY HOSPITAL - ADOLESCENT INPATIENT PROGRAM (422-4541)

This program provides services for adolescents, ages 12-18, in several categories:

(1) Crisis intervention services are available for youth who are in a crisis situation and need only a very short period of hospitalization. This category includes assessments and efforts to get the patient back into the community as soon as possible.

(2) Other adolescents might need a medium-length period (two weeks) of hospitalization. Their stay would include an assessment. At the end of the two weeks, the patient could be discharged and possibly referred for out-patient therapy. Or, the patient might be determined to need a program provided in the next category.

(3) Longer term treatment programs in the hospital are also available for periods ranging up to six weeks. Some patients might be referred directly to this category if they've been seen by a psychiatrist already.

The unit has 20 beds and can admit both boys and girls. It is a secure (locked) unit. The staff includes psychiatric nurses; recreational, music, and occupational therapists; therapy assistants and psychiatric technicians; and its own psychiatrist as medical director. Treatment programs are individually planned, and family therapy can be included.

MERCY HOSPITAL - ADOLESCENT DAY TREATMENT PROGRAM

During this program, patients would remain in their homes but come to the hospital for their treatment and academic programs during the day. The program can take 16 adolescents, ages 12-18.

Parents can approach the unit directly by calling 422-4542; they would be invited in for an intake interview and, if their child had no psychiatrist, one would be suggested.

A staff psychiatrist would coordinate the child's program, while each child's own psychiatrist would meet weekly with the hospital team. The unit team also works closely with the child's family and community (for instance, school social workers are included in the assessment process and discharge meetings as are probation officers, if the child has one, and school counselors).

The unit is staffed with a psychiatrist, a registered nurse, and two case managers (who are involved with intake and the direction of the child's program) plus music, family and recreational therapists. During the program the adolescents will take part in group therapy and in several kinds of individual therapy (crisis work counseling; responsibility training; and identifying, recognizing, and expressing feelings).

Mercy Hospital does have Hill Burton funds available although these cannot be used for outpatient programs. The costs could also be covered by insurance or Medical Assistance.

(See pp. 61-62 for information on the University of Minnesota Hospitals.)

St. Paul area

ST. JOSEPH'S INPATIENT PSYCHIATRIC UNIT

This is an adult unit, but it will accept adolescents and has taken children younger than 10, according to its supervisor.

A stay on the unit would last for two or three weeks; it's geared for crisis intervention, evaluation, and short term treatment.

A psychiatric work up is done by a psychiatrist upon admission.

Parents would be asked to have their own doctor make a referral for the child's placement in the unit. A doctor who's not a psychiatrist can admit the child; however, the youngster would then need to be seen within 48 hours by a psychiatrist.

If parents call the unit directly 291-3052 and have no doctor, they'd be asked to bring the youngster to the hospital's emergency room where the doctor on duty and a nurse from the unit would make an assessment and could decide to admit the child.

Six to eight psychiatrists are generally active on the unit, and patients are seen by a psychiatrist an average of five times a week.

The staffing includes recreational, art and occupational therapists; a coordinator of group therapy; a social worker; and nurses. In addition to psychotherapy with his/her psychiatrist, the adolescent would have one-to-one therapy sessions with an assigned nurse once or twice or more times a day.

Costs of services could be covered by Medical Assistance or insurance; the hospital also has Hill Burton funds available.*

BETHESDA CRISIS UNIT

This is a general crisis unit (i.e., primarily for adults) but it will take adolescents. According to the unit's head nurse, because the unit is open or unlocked, placement here would not be appropriate for children who are a danger to themselves or to others.

Parents may call the unit directly (221-2308) if they don't have a physician with admitting privileges at Bethesda, and they will be referred to one of the staff psychiatrists who will become the admitting physician. Also, the parents may bring the child to the emergency room, and the physician on duty will make a brief assessment and contact a staff psychiatrist for admission.

The unit has access to a psychologist and a psychiatrist who would help with the initial assessment.

Round-the-clock nursing is provided by registered nurses; the unit's total capacity is 22 beds, and there is no limit on the number of those that may be taken by adolescent patients.

Those adolescents in need of long term service would be referred to community-based programs.

Services through Bethesda could be eligible for insurance reimbursement and Medical Assistance. The hospital also has Hill Burton funds available.

MOUNDS PARK ADOLESCENT EVALUATION UNIT

A typical stay on this inpatient unit would last from ten to fourteen days, during which stay an evaluation would be made. Those adolescents whose problems are found to be primarily psychological (rather than related to chemical abuse) might then receive some short term treatment. The unit's practice is to keep such patients if it's felt their problem can be handled in less than a month.

The unit has 14 beds and is locked; it will take both boys and girls, ages

*Although a hospital may have Hill Burton funds, depending on the time of year its annual allotment may be used up. Discuss this with the individual hospital.

12-17.

A private doctor could handle referrals; however, parents can also approach the unit directly, 774-5901. The unit's psychiatrist would be the admitting doctor in that case. An outpatient unit at Mounds Park is also planned in the near future.

MOUNDS PARK - OTHER INPATIENT UNITS

Mounds Park will admit adolescents down to age 13 to both their open and closed general inpatient units, primarily intended to serve adults.

A stay on one of the units could be for evaluation and crisis intervention, or some patients might stay for two to four weeks and begin short term treatment.

In an emergency, parents could bring an adolescent to the hospital's emergency room; the doctor on duty would determine if a crisis does exist and, if so, would contact a staff psychiatrist to make the admission. If parents called the unit, 774-5901, they'd be put in touch with one of the hospital's admitting doctors.

The unit is staffed by nurses, their assistants, and a recreational and an occupational therapist. Patients are seen daily by a psychiatrist and also have one-to-one therapy with a nurse assigned to them each day. The adolescents on the ward are included in adult activities as much as possible, according to the unit's head nurse.

Services at Mounds Park could be eligible for insurance reimbursement and Medical Assistance; the hospital has Hill Burton funds available.

ST. JOHN'S FAMILY THERAPY CENTER

The Family Therapy Center is an outpatient program for people of all ages, including children. It provides individual or family therapy as needed. The program is supervised by a licensed consulting psychologist, directed by licensed psychologists, and staffed directly by social workers with master's degrees.

A parent can contact the program directly at 228-3484; if screening shows that the child is a candidate for the Center's services, his family doctor would then be asked for approval in order that the costs could be covered by insurance.

Hill Burton funds are also available at St. John's, and there is a sliding fee scale.

ST. PAUL RAMSEY PEDIATRIC PSYCHOLOGY

This is an outpatient unit that accepts children up to age 18. The unit does evaluations, educational assessments, family (or crisis) intervention, training in parenting skills, and individual and family psychotherapy for troubled children.

It's staffed by a licensed consulting psychologist, a licensed psychologist, and a pediatric counselor.

The length of the treatment program is dependent upon the client's needs.

The unit can take only a limited number of cases; there is currently a month's delay between the time a referral is made and the evaluation is done except in emergencies. Parents can call the unit directly 221-3680 to make an appointment.

St. Paul Ramsey also has a psychiatrist who will see children referred to him by the hospital staff. He limits those he sees to children in need of medication and those who are most seriously disturbed.

Costs of service at the hospital can be covered by insurance or Medical Assistance. Hill Burton funds may be available to patients (or their

families) who've applied for Medical Assistance but been found ineligible.

UNITED HOSPITAL ADOLESCENT PSYCHIATRIC UNIT

This is an inpatient program for boys and girls, ages 11 through 17 or 18. The unit has 18 beds and is locked.

A stay on the unit would generally last for a minimum of two weeks and consist mainly of evaluation although some of the beds are reserved for patients receiving longer term treatment.

Parents who approach the unit directly by calling 298-8250 would be given a list of admitting psychiatrists, one of whom would need to approve the child's admission.

A complete psychiatric workup would be done on patients when they enter, and recommendations would be made for long term programs after they leave the unit.

Some treatment would begin during their 30 day stay; they could take part in individual psychotherapy, family therapy, occupational and recreational therapy, and groups that work on improved communication.

The unit is staffed by nurses, mental health associates (persons with bachelor degrees in a human service field), staff psychiatrists, a family therapist, and a social worker.

There is also a parent support group connected with the unit.

Costs of United's services could be covered by insurance or Medical Assistance. The hospital does not have Hill Burton funds.

University of Minnesota Hospitals: Division of Child and Adolescent Psychiatry

Services provided to children and adolescents with psychiatric problems by the University of Minnesota hospital can take several forms.

The Division of Child and Adolescent Psychiatry offers diagnostic evaluations, consultations to community agencies and care providers and to schools, outpatient treatment, and inpatient care for those children in need of hospitalization.

The Division is staffed by a "multidisciplinary" team that includes psychiatrists, psychologists, social workers, psychiatric nurses, and education specialists. Further, the Division's staff members work with specialists from other departments within the hospital such as pediatricians, pediatric neurologists (specialists who deal with the brain), and speech and language specialists.

After a child or adolescent has been evaluated and assessed by the Division, any of several recommendations might be made.

First, services for the youngster might be sought through an agency or practitioner within his or her home community. University staff members would aid in the search for an appropriate program, serve as a consultant to the professionals within the community program, and "follow up" on the youngster's progress.

Second, the University itself might continue to see the child or adolescent as an outpatient, offering its own continuing program of therapy. The program could include family therapy, individual therapy, group therapy, and/or medication.

Third, the Division operates a ten-bed inpatient unit for children ages 4-12 in need of hospitalization. Children in that program would receive a full day's schedule of academic classes, individual and group therapy, field trips, and occupational therapy.

The inpatient unit enables the University to make thorough diagnoses of the hospitalized children and to plan treatment strategies. Children who need long term residential placements following their period of hospitalization would be referred somewhere else.

An inpatient unit for adolescents formerly operated by the Divsion has now been closed. Those adolescents whose emotional or psychiatric problems are due to neurological impairment (brain damange) and who need hospitalization would be referred to the pediatric neurology department. Other adolescents might be hopitalized on an adult unit for a short term stay.

Another unit within the Division contains "school liaison" staff people who link what's happening in a youngster's home school with the results of his or her evaluation and assessment done by the University and the recommended treatment program.

The school liaison staff works on the outpatient cases, perhaps observing a child in his or her school setting and noting how the youngster relates to classmates. The liaison sees what resources are available for continuing service to a child within his or her own community, shares that information with the University's assessment team (who will use it in shaping their final recommendations), and gives the child's

home school information on how they might work best with the youngster based on the findings of the assessment team.

Children and adolescents using any of the Divison's services might come to the University in one of several ways. A home school district, for instance, could decide that one of their students should be evaluated at the University. Referrals might be made by family doctors or a social service agency. Finally, parents might decide on their own to contact the Division's intake number, 373-8871.

Physician fees for out-patient services are charged on a sliding scale according to the family's ability to pay. An additional fee is charged by University Hospitals.

In general, services through the Hospital are eligible for Medical Assistance or insurance reimbursement. All patients are prescreened for coverage and referred to appropriate agencies for assistance if necessary.

University Hospitals also has a unique kind of assistance called "University Hospital (UH) Papers." The family applies through their local county welfare offices. Eligibility is based on income and other circumstances such as large medical bills and limited or exhausted insurance. UH Papers are only good at University Hospitals and do not cover physician fees.

Six financial representatives do preadmission screening. Families should call (612) 373-8664, and they will be directed to the appropriate representative.

Residential Treatment Centers

Residential Treatment Centers (licensed through the state as "rule 5" facilities) are designed for emotionally disturbed youngsters who need placement outside their homes, around-the-clock supervision, and treatment programs.

Although Residential Treatment Centers (RTC) do offer treatment programs, they are not required to be directed by persons who are licensed psychologists or psychiatrists. Rather, the director or administrator can be a person with a bachelor's degree in a behavioral science (special education, psychology, social work, or vocational counseling) plus five years of experience in residential treatment.

Services by a qualified social worker must be provided by the RTC, and in those Centers with more than 24 children, the social worker must have a master's degree. The Treatment Centers must also have the services of a psychologist, psychiatrist, and physician available to those children requiring such services -- though those professionals need not be on the RTC's staff. For other types of RTC personnel, there are no academic requirements.

A child in an RTC would probably receive his academic instruction and his therapy programs at the Center itself through arrangements with the local school district. However, clients at some RTCs may leave the premises and go to a local school, often for a Level V educational program.

Right now, according to the Minnesota Department of Human Services Income Maintenance Bureau, the state does not allow Medicaid reimbursement for treatment programs delivered by Rule 5 or RTC facilities. Thus, expenses are born by parents, insurance plans, and the counties from which the children come. However, as noted earlier in this booklet, the types of programs which may be eligible for Medicaid coverage are being reconsidered by courts and the federal administration. Accordingly, this paragraph should not be considered as one that is "written in cement."

Because of the counties' involvement in payment, the typical route by which a child would enter an RTC is through his or her county's human or social services agency. That agency would have to approve the placement.

Thus, a parent's first step in seeking placement of his or her child would usually be to contact the county office, not the treatment center itself.

In Hennepin and Ramsey Counties, the county then pays the treatment center directly for costs of service to a youth whose placement it's approved (the costs of his or her academic instruction are born by his home school district). The county then seeks whatever reimbursement it can obtain from the parents and their insurance company. Deviations from this procedure may occur in other counties.

Frequently, parents have sought to place a child themselves in a treatment center, being wiling to pay for his or her care and treatment without county help. Currently, the state Department of Human Services allows parents to make this type of independent placement, and some RTCs will accept children placed by their parents without county involvement and approval.

Others are strictly following guidelines suggested by a recently-passed state law and believe that parents cannot independently place their child in an RTC; they accept only children that the county or some other social service agency places even when parents are

willing to pay for treatment and care costs themselves.

A guide that describes the staffing, programs and eligibility requirements of the RTCs that belong to the Minnesota Council of Residential Treatment Centers can be obtained by writing to Barbara W. Kaufman, 1418 Griggs-Midway Building, 1821 University Avenue, St. Paul, MN. 55104, or calling (612) 645-0267. A complete listing of all RTCs in Minnesota can be requested from Cheryl Nyhus in the state Department of Human Services at (612) 296-4037.

RTC's can be found in the following Minnesota towns and cities: Minneapolis, St. Paul, Bemidji, Anoka, Wahkon, Austin, Faribault, Stillwater, St. Peter, Winona, Duluth, St. Cloud, Isanti, and Eagan.

State hospitals

Programs exist at two state hospitals for mentally ill children and/or adolescents, one at Willmar and another at Brainerd. Parents can no longer independently place their child at a state institution. The placement must now be approved by the human or social services department of the county in which the family resides. Therefore, parents who think a state hospital program looks like a possibility for their child would need to contact a county social worker first.

At the time of a child's admission to a state hospital, the parents would be interviewed by the reimbursement officer to determine resources available to pay the cost of care. If the parents have insurance, the carrier would be billed first. If the child is not covered by insurance or if the benefits have been used, the parents may be charged for a portion of the cost, which is currently $95.80 a day. The charge would be based on the parents' income and numbers of dependents. Parents whose income is less than $11,000 per year would not be required to pay.

The child may also be eligible for Medical Assistance to pay all or a part of the cost. In addition, the county may be charged up to ten percent of the cost. If no other resources are available, the State would pay the balance of the cost.

WILLMAR STATE HOSPITAL -- (612) 231-5100

Willmar has two units for adolescents, an open one with 20 beds for boys and 24 beds for girls, and a closed one with six beds, all for boys (they're trying to develop a similar closed program for girls).

The hospital will take adolescents, ages 12-17, into the program though its acting director said that patients really need to be in the treatment program before they're 16 in order to accomplish much.

The length of stay on the ward is about thirteen months and can be extended if needed. The program is staffed by three master's degree level social workers, a psychologist with a master's degree, a recreational and an occupational therapist, a nurse, one part time psychiatrist, one part time physician, and three group supervisors who work with the 44 people providing direct care to the children.

Most therapy is done on an individual basis although there are also a number of groups. The patient's whole environment in the unit is highly structured with everyone and everything s/he encounters considered part of the treatment plan. His/her routine daily experiences serve as "raw material" for his/her therapy; i.e., they might be discussed during counseling, and s/he might apply what's learned in counseling to future routine encounters.

A great deal of "reality" therapy is also used with the patients; under this approach, the youth is encouraged to take responsibility for his or her own actions and to deal with what <u>is</u> rather than with how he or she would <u>like</u> things to be. Each patient also has an individual behavior modification plan in operation.

In addition to patients who are in the program due to an emotional disturbance alone, some have come through the courts and also have a delinquency problem related to an emotional disturbance.

BRAINERD STATE HOSPITAL: THE MINNESOTA LEARNING CENTER (218) 828-2201

When the Owatonna State School was closed, the Minnesota Learning Center (MLC) at the Brainerd State Hospital was given responsibility for those youngsters

in the state with severe behavior problems.

According to MLC's director, the client population was originally borderline or mildly mentally retarded. The program is still funded to serve that population. However, in the last few years, he said, judges have sent clients to the Center who have IQ's as high as the 120-130 range. The current population is a mix of mildly retarded and emotionally disturbed youngsters. However, except through a court order, the Center can still not accept clients who are not retarded. Patients, who could range in age from five to eighteen, can come through the court system, or they could be youngsters not in trouble with the law. In the case of the latter, parents would need to begin to seek placement through a county social worker.

Each youth in the program has an individual treatment plan in place; it's based on objectives defined by his parents and/or the county. They outline what skills he needs in order to survive in a community environment. The MLC helps him learn what the parents, social workers, and/or courts have said he needs to know in order to be released.

Therapy centers on an individual approach to each youngster, rewarding him for exhibiting at least an approximation of the skills he needs in order to survive and reinforcing his appropriate reactions and responses to events and interactions with other people. Social skills are taught through group therapy.

The MLC is not geared for youngsters with "medical model" mental illnesses (such as schizophrenia or depression). However, the program does have access to a psychiatrist who serves as medical director for the whole hospital. He can serve as a consultant and prescribe medications if absolutely necessary. The program uses the medication approach to treatment for as short a while as possible.

The program is staffed largely by psychologists, who serve as the program's director, leaders of teams of professionals providing treatment for each child, programmers for the child's treatment plan, and parent trainers (the last works with a youngster's parents and teachers prior to his discharge).

There are also nurses and shift supervisors who hold bachelor's degrees in psychology and oversee the direct child care workers.

Finally, another staff member follows up on youngsters who've been released from the hospital, determines what problems they may be encountering, and may make changes in the hospital's program to prevent such problems from occurring as other youngsters are released.

The MLC is not a locked facility; however, if a child were presenting a danger to himself or others, he could be separated from the unit in a secure room.

The program is designed to last eight to nine months; its total capacity is 64 beds. However, it's licensed to take only 48 children, and its present population is 37.

Parent participation is encouraged in the MLC program. It's hoped they can be taught the procedures that work well with their youngster. Some formal lessons are given through the Center. Staff members will also make home visits, and the parents are encouraged to come to the Hospital and observe.

When agencies work together

A flaw in our present system of mental health care may be the frequent lack of communication between service providers. For instance, a community mental health center could be involved in a child's emotional needs. A county's welfare department could be involved with the financial and social needs of the child's family, needs that have perhaps grown greater because of the youngster's emotional disorder. A school district could be involved with a child's educational and psycho-educational needs. Yet, theoretically, none of the three might be talking together.

Among programs attempting to overcome the communication gap is one operating in Hennepin County that brings together schools, the county, and parents.

FAMILY FOCUS, a program administered by the Bloomington school district, began as an attempt by Hennepin County to see if some students who would previously have been sent to a residential treatment center could possibly remain in their homes - if a comprehensive treatment program were available for them in their school setting.

While the program serves primarily emotionally disturbed students from the Edina, Eden Prairie, Bloomington, and Richfield school populations, Bloomington serves as its administrator and hires the academic teachers, aids, and a coordinator.

The main component of Family Focus is a day treatment program with a capacity of twelve students in grades K-6 (approximately 5-13 years of age). The academic ratio per class is six students for one teacher and one aid, and both teachers are licensed in teaching emotionally disturbed children. All four member districts are responsible for the special education personnel costs associated with the students' academic instruction.

Hennepin County hires and pays for the treatment coordinators: a psychologist, social worker, and family therapist.

Family participation in the counseling process is a requirement of the program; the family therapy sessions are usually held once each week at no cost to the parents.

Each student is assigned a treatment coordinator to work with him or her and the child's family.

The child's academic day is seen as a treatment environment with social interaction, behavior modification approaches, and relaxation periods all integrated into his or her daily routine. An integrated treatment plan is developed for each student according to his/her needs and includes academic as well as social/emotional goals.

The youngster's individual therapy could include play therapy, one-to-one counseling, group therapy, and activity-oriented therapy (puppetry, dramatics, or pottery, for example). The therapy programs would be handled by teachers and the treatment coordinators.

First preference in placement is given to students residing in the four member districts. Next to be placed would be students referred from other schools in Hennepin County.

Currently, Family Focus allows the initial contact with its program to be made by schools, parents, or another agency; its number is 884-8831. In the latter two cases, the program's director would then notify the child's home school district of the placement request and ask that the school send a representative to a meeting where appropriate placement would be determined.

A second component of Family Focus is an

"outreach" program for Level IV emotionally disturbed students in the member districts. If parents are willing to participate in counseling, Family Focus treatment staff will provide counseling to the student and his/her family and consultation to the youngster's teachers. Mutually agreeable meeting places will be arranged.

Family Focus is too new to have produced statistics about its success ratio with the students it serves. However, the degree of coordinated effort it promotes through the involvement of school, county, and parents working together makes it a program that deserves attention and observation.

Looking at the future

In Minnesota, one of the greatest needs of children with emotional disorders and their families is for a group specifically designed to address and try to overcome the problems discussed earlier in this booklet:

1. the lack of adequate mental health services and programs in many parts of the state,

2. the need for support groups to help parents deal with the stigma still too often associated with mental illness and with the specific difficulties of dealing with an emotionally disturbed child,

3. the need for respite care services, and

4. the development of a true continuum of programs for students with emotional disorders throughout the state's school districts.

The following letter is from an organization in Kansas City that meets the second need listed above, that for support groups for parents. The letter suggests a possible pattern that interested persons in this area might follow to begin something here.

Kansas City Association for Mental Health
4049 Pennsylvania - Third Floor
Kansas City, Missouri 64111
Phone 816-561-6675
June 16, 1983

Dear PACER,

In response to your request for information about "Parents Supporting Parents," I am enclosing a copy of our brochure and several copies of our monthly newsletter.

Parents Supporting Parents was developed in 1979 on a special $3,000 grant from the Heart of America United Way. A committee of parents and professionals developed the structure but there have been no mental health professionals involved in the operation of P.S.P. since we began functioning as a public support group in September, 1979.

Parents Supporting Parents has monthly program meetings led by one or two co-facilitators and features a speaker/presenter on an issue of relevance to parents dealing with a troubled child. We allow time for discussion of other problems facing the parents attending. (about 3/4 of the parents that attend are parents of adolescents, with the others being parents of younger children or of adult children - with an age range of 3-32 years.) In addition, we offer monthly area meetings for discussion purposes in 3 outlying locations of our metropolitan area.

The key to making people comfortable with the sharing of such personal and painful experiences has seemed to focus on the fact that the facilitators start each sharing portion with their own experiences. Hearing our extensive problems seems to relax others and over the three years only a handful of people have declined to share their problems. Most are eager because they have had no one with whom to share and they finally find someone who understands their feelings of frustration, anger, fear, and guilt. As a result, one of our pre-requisites for co-facilitators is that they are, or have been, a parent of a troubled child.

I strongly urge any agency that considers developing a parent support program to require parent involvement in its development and to turn the operation over to the parents. If you have a staff member who has personally experienced dealing with a troubled child, he/she might be the best one to liaison between the group and the agency. If professionals run the group, no matter how compassionate and sensitive they are, the parents will feel intimidated, threatened, and/or less powerful in resolving their own problems. Then you don't have the magic of a self-help support group.

Our format usually begins with the sharing period - a brief introduction of themselves and a comment about the child with whom they are concerned. This takes perhaps 20-40 minutes but provides the speaker with insight to the members of the group and relaxes the group considerably. (Prior to the sharing, they tend to look around and assume no one else is dealing with as serious a problem as they are.) Following this sharing period, the speaker spends about 40 minutes on his/her presentation with no reimbursement. Many, early on, could see the need we could meet and believed in us.

The area meetings have a similar format only without speakers and with a smaller attendance as a rule. Some persons attend the Program Meeting as well as their Area Discussion Meetings while others choose to attend one or the other.

Some attend meetings regularly for six months to a year, others attend every 2-4 months, and some attend once and draw reassurance from that experience or keep in touch only by phone. Our attendance at program meetings varies from 8-40, and about 3/4 are mothers and 1/4 fathers. Once people begin sharing, it's like a dam has burst, and our 7:30 meetings regularly go until 10:00 p.m. or beyond. We encourage those attending to exchange phone numbers to provide between-meeting support systems.

This is rather generalized information about Parents Supporting Parents. I hope you find it useful, and I encourage you to consider beginning something of its type for the parents in distress in your locale.

History suggests that progress has been made in other disability areas when parents have organized and recognized that their children's needs are shared with many others and that solutions come more easily when pursued by a group.

A support group, once established and having brought parents together, might then serve as a foundation to begin advocacy efforts. Working with the many professionals who are already actively advocating for children with emotional disorders, the gaps in services can be better addressed than when one parent struggles alone to find elusive answers.

Persons interested in beginning an organization for parents of children with emotional disorders may call PACER (612-827-2966) and leave their names and numbers. PACER will put such parents in touch with one another and see if something might begin.

Existing groups

Though not designed to address specifically the needs of emotionally disturbed children and adolescents, the following organizations can be a resource for parents interested in general, mental health concerns.

MENTAL HEALTH ADVOCATES COALITION OF MINNESOTA, 265 Fort Road (W. 7th St.), St. Paul, MN. 55102, (612) 222-2741

MENTAL HEALTH ASSOCIATION OF MINNESOTA, 5501 Green Valley Drive, Suite 103, Bloomington, MN. 55437, (612) 835-9046

APPENDIX

Credit to:

I. PACER found the following books and other written materials of great help in compiling this guidebook.

The Caring Family; Kayla F. Bernheim, Richard Lewine, and Caroline T. Beale; Random House; New York; 1982.

"Guideline Handbook for Defining and Serving Students with Emotional/Behavioral Disorders," (draft), Minnesota Department of Education, Winter, 1983.

Help for Your Child, A Parents' Guide to Mental Health Services; Sharon Brehm; Prentice-Hall, Inc.; Englewood Cliffs, N.J.; 1978.

"Information from Closer Look", a bibliography distributed by Closer Look under its contract with the U.S. Department of Health, Education, and Welfare, February, 1978.

Report (non-published) from the Conference on the Status of Emotionally Disturbed Children in Minnesota, June 2-3, 1978, sponsored by the Minnesota State Council for the Handicapped, Metropolitan Committee on Behavioral Problems, and the College of St. Thomas Special Education Program.

Unclaimed Children - The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services, Jane Knitzer, Children's Defense Fund, Washington, D.C., 1982.

"Who Do We Blame? What Good Does It Do?" Exceptional Parent Magazine; December, 1982.

You Are Not Alone, Understanding and Dealing with Mental Illness; Clara Claiborne Park and Leon N. Shapiro, M.D.; Little, Brown and Company; Boston, 1976.

II. The following people were helpful in describing the various mental health programs and systems to be found in the state of Minnesota, and we extend our thanks and appreciation to them for the time they spent.

Barbara Amran, Family Focus, Bloomington School District
Jeannie Bailey, Fairview Downtown Hospital
Gene Bitterman, Intermediate District 287
Rochelle Brandl, North Memorial Hospital
Patrick Carroll, Willmar State Hospital
Millie Casperson, Hennepin County Crisis Intervention Center
Mary Cichon, Hennepin County Mental Health Center
Rick Cunningham, Ramsey County Human Services
Mary Davies, Human Resource Associates
Earl Denker, Minnesota Department of Human Services
Marilyn Doyle, St. Paul Ramsey Hospital
John Drozdal, Hennepin County Department of Community Services
Trudy Dunham, Department of Human Services
Carolyn Elliott, Minnesota Department of Education
Mary Emerick, Fairview Downtown Hospital
Eva Erickson, Abbott Northwestern Hospital
Mary Faulkner, Mercy Medical Center

Anne Gearity, Minneapolis Children's Health Center
Donna Gedo, University of Minnesota Hospitals
Dr. Larry Greenberg, University of Minnesota Hospitals
John Gross, Minnesota Department of Commerce
Barbara Harer, St. Joseph's Hospital
Ada Hegion, Hennepin County Medical Center
Kathy Henke, Mercy Medical Center
Cheryl Hughes, Fairview Downtown Hospital
Kathy Knight, Fairview Downtown Hospital
Dr. Michael Koch, St. Paul Ramsey Hospital
Marilyn Lee, Wilder Foundation
Leslie Marcus, St. Joseph's Home for Children
Sue Margot, University of Minnesota Hospitals
Karen Masters, Fairview Downtown Hospital
Don Mockenhaupt, Ramsey County Community Human Services Department
Bev Montgomery, Minnetonka School District
Jan Navarro, Bethesda Hospital
Lorraine Nelson, Golden Valley Health Center
Bill Novak, Minnesota Department of Human Services
Cheryl Nyhus, Minnesota Department of Human Services
Jill Olson, Abbott Northwestern Hospital
Ronnie Pashwa, North Memorial Hospital
Dr. Jack Peverill, Hennepin County Mental Health Center
Deb Quist, Mounds Park Hospital
Bev Richardson, Mounds Park Hospital
Claude Riedel, St. John's Hospital
Ashley Rose, Department of Human Services
Terry Sarazin, Department of Human Services
Pat Solomonson, Mental Health Advocates Coalition
Pat Steingruebl, Minnetonka School District
Dr. Don Thomas, Minnesota Learning Center
Bob Wedl, Minnesota Department of Education
Chris Welch, United Hospitals, Inc.

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Additional reading

The following are books related to the needs of parents of children with emotional disorders. They have been recommended by persons or organizations in this field though they have not all been personally read and reviewed by PACER staff members.

The ABC's of Hanging on While Raising a Family with a Disturbed Child; Betty Oliver; Claitor's Publishing Division; 3165 South Acadian; P.O. Box 3333, Baton Rouge, LA. 70821; 1976 - A book with useful suggestions written by the parent of a young emotionally disturbed child.

Behavior Modification; Irving Dickman; Public Affairs Pamphlet No. 540; Public Affairs Pamphlets; 381 Park Avenue South; New York, N.Y. 10016; 1976 - An explanation of a method to help children change their behavior through the use of positive rewards.

Born To Win; Muriel, James, and Dorothy Jongeward; Addison-Wesley Publishing Company; Reading, MA. 01867 -- a book that explains why certain communication patterns cause trouble and suggests how to change the patterns.

The Child's Emotions: How Physical Illness Can Affect Them; Joyce Wasserstein and Herbert Yahraes; United States Department of Health, Education, and Welfare; National Institute of Mental Health; 5600 Fishers Lane, Rockville, MD. 20852; 1977 (DHEW Publications No. 77-497; single copies are free upon request) -- A report with findings about (1) the relationship between various physical conditions and abnormal behavior, (2) behavior problems and other common reactions to sickness, and (3) emotional problems associated with hospitalization.

A Consumer's Guide to Mental Health Services; Department of Health, Education and Welfare; Alcohol, Drug Abuse, and Mental Health Administration, 5600 Fishers Lane; Rockville, MD. 20857; 1977 - A pamphlet that describes different treatment methods, lists warning signals, defines various mental health workers and sources for other information and assistance (DHEW Publication No. ADM 77-214 - single copies are free upon request)

Help for Your Troubled Child; Alicerose Barman and Lisa Cohen; Public Affairs Pamphlet No. 454; Public Affairs Pamphlets, 381 Park Avenue S., New York, N.Y. 10016; 1970 - An aid for parents to use in deciding when their child or teenager needs the help of a psychotherapist. (Public Affairs Pamphlets also has a publications list available with other pamphlets about mental health that can be ordered.)

A Home Training Program for Young Mentally Ill Children; Nanette Doernberg, Bernard Rosen, and Romannie Walker; League School for Seriously Disturbed Children; 567 Kingston Avenue; Brooklyn, N.Y. 11203; 1968 (single copies are free upon request) - A book that presents the League School's training programs for use by parents of severely disturbed children.

Learning and Growing; Laurie and Joseph Braga; Prentice-Hall, Inc.; Englewood Cliffs, N.J. 07632; 1975 -- A book about the ways in which children grow and learn and the kinds of behaviors you are likely to see at different stages of your child's growth.

The Magic Years; Selma Fraibergh; Charles Scribner & Sons; 597 Fifth Avenue; New York, N.Y. 10017; 1959 -- By an author who's a child psychoanalyst, a book that offers understanding and help in dealing with young children's emotional needs.

Parent Effectiveness Training; Dr. Thomas Gordon; Peter H. Wyden, Inc; 750 Third Avenue, New York, N.Y. 10017 - A book used as a base for many parenting classes offered by schools, adult education programs, churches, and other community programs; the classes are designed to help parents learn how to raise happier and more responsible children.

A Psychiatric Glossary; American Psychiatric Association; Publications Office, 1700 Eighteenth St., N.W.; Washington, D.C. 20009; 1975 -- A book that explains common psychiatric terms and includes several tables that list drugs used in psychiatry, schools of psychiatry, and some psychological tests.

Surviving Schizophrenia - A Family's Manual; E. Fuller Torrey, M.D.; Harper & Row; New York, 1983

Through the Mental Health Maze - A Consumer's Guide to Finding a Psychotherapist; Health Research Group, 2000 P St. N.W.; Washington, D.C. 20036.

Many books on this list originally appeared in a bibliography prepared by Closer Look, a national information organization.